



*"People  
helping people  
help  
themselves"*

Mitchell E. Daniels, Jr., Governor  
State of Indiana

***Indiana Division of Aging***  
402 W. WASHINGTON STREET, P.O. BOX 7083  
INDIANAPOLIS, IN 46207-7083

E. Mitchell Roob, Jr, Secretary

Thank you for your interest in providing services for the Medicaid Home and Community-Based Services Waivers. Enclosed are the following documents:

- Acceptance of Adult Foster Care Rule Changes
- Adult Foster Care Rates
- Adult Foster Care Level of Service Assessment/Evaluations List
- Adult Foster Care Provision and Certification Standards and Guidelines
- Adult Foster Care Survey Tool
- Adult Foster Care Proposed Rule Change Document
- Nursing Facility Level of Care Waiver Provider Information website sheet
- Provider application for the Nursing Facility Level of Care Waiver (s)
- Provider Agreement (Schedule A)
- W-9 Tax Identification Number and Certification
- County Survey with a list of the 16 Area Agencies on Aging

Please complete the application, provider agreement, W-9, and county survey with dates and signatures and return them along with the specific documents and other information required for the service (s) for which you wish to be approved.

Please contact Ava Y. Taylor, Program Manager at (317) 232.7149 or Linda Wolcott, Certification Specialist at (317) 234.0373 with any questions you may have.

To request additional waiver documents, contact the Waiver Secretary at (317) 232.7122.

The completed application and attachments should be returned to:

Linda Wolcott, Waiver Operations  
MS 21 Division of Aging  
402 West Washington Street, Room W454  
P.O. Box 7083  
Indianapolis, Indiana 46207-7083

Enclosures



Equal Opportunity/Affirmative Action Employer

## ***Adult Foster Care Acceptance of Rule Changes***

Adult Foster Care Standards & Guidelines may change due to the Administrative Rule Process. Adult Foster Care Providers must comply with all changes made to the Standards & Guidelines as a result of the Administrative Rule Process.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **Adult Foster Care Medicaid Waiver Rates effective 7-1-07**

Adult Foster Care Services		Unit	Cap Rate	Code & Modifiers	Prior Authorization & Audit Criteria
Adult Foster Care - Level 1	1	Day	\$55.00		The rate is \$55.00/day. Max 1 unit/day
Adult Foster Care - Level 2	1	Day	\$65.00		The rate is \$65.00/day. Max 1 unit/day
Adult Foster Care - Level 3	1	Day	\$75.00		The rate is \$75.00/day. Max 1 unit/day

# Adult Foster Care

Service Provision and Certification Standards  
for the Aged and Disabled Waiver  
FSSA Waiver Services  
Division of Aging



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## I. Definitions

### A. Adult Foster Care

Adult Foster Care (AFC) is a comprehensive service provided under the Aged and Disabled (A&D) Medicaid Waiver, as administered through the Family and Social Services Administration's (FSSA) Division of Aging (DA). All descriptions in this document refer to the service as provided in the A&D Waiver.

An AFC consumer resides with a caregiver and up to two other consumers, in a home owned, rented, or managed by the AFC provider, in order to receive personal assistance in a home setting that is safe and secure.

The goal of the Home and Community Based Service (HCBS) Medicaid Waiver service is to provide necessary care while emphasizing the consumer's independence. This goal is reached through a cooperative relationship between the consumer (or the consumer's legal guardian), the consumer's HCBS Medicaid Waiver case manager, and the care provider in a setting that protects and encourages consumer dignity, choice, and decision-making. Consumer needs shall be addressed in a manner that support and enable the individual to maximize abilities to function at the highest level of independence possible. The service is designed to provide options for alternative long-term care to persons who meet Nursing Facility Level of Care (LOC), and whose needs can be met in an AFC setting.

The AFC home shall include a maximum of three consumers. The AFC caregiver's family may also reside in the home, allowing the special one-to-one attention and care that the consumer may desire and deserve. The goal is to preserve the dignity and self-respect by ensuring high quality, professional care in a non-institutional setting. Care is to be furnished in a way that fosters the independence of each consumer to facilitate aging in place in a home environment that will provide the consumer with a range of care options as the needs of the consumer change.

### B. Other Definitions within AFC Service under A&D Waiver

For purposes of these Certification Standards for the FSSA Waiver Services HCBS Medicaid Waiver Programs for persons who are aged or medically disabled, the following definitions will apply:

**"Activities of Daily Living (ADL)"** - Those personal functional activities required by an individual for continued well-being including mobility, dressing, bathing, eating, toileting, and transferring.

**“Adult Foster Care Home”** – As provided under the A&D Waiver, the family home in which consumer care is provided to three (3) or fewer elderly individuals or adults with physical and/or cognitive disabilities who are not members of the provider’s or primary caregiver’s family. The care is provided in a home-like environment for compensation. For the purpose of these certification standards, the AFC home does not include any house, institution, hotel or other similar living situation that supplies room and/or board only, if no consumer thereof requires any element of care.

**“Adult Foster Care Provider”** - A provider of AFC Care services, under the A&D waiver, who is enrolled in the HCBS Medicaid Waiver Programs for persons who are aged or medically disabled.

**“Advance Directive”** - The legal document signed by the consumer, giving instructions for health care should she/he no longer be able to give directions regarding her/his wishes. The directive gives the consumer the means to continue to control her/his own health care in any circumstance.

**“Aging in Place”** - Residing in a care environment that will provide the consumer with a range of care options as the needs of the consumer change. Aging in place does not preclude assisting a consumer in relocating to a new care environment, if necessary.

**“Area Agency on Aging” (AAA)** - An established public agency within a planning and service area designated under Section 305 of the Older Americans Act which has responsibility for assisting individuals in the Waiver process. For the purpose of these Certification Standards, AAAs contract with the state to perform specific activities in relation to administration of the FSSA Waiver Services HCBS Medicaid Waiver Program.

**“Attendant Care”** – Attendant Care services primarily involve “hands on” assistance with physical dependency needs, however other needs may be met under Attendant Care that assure safety in, and connection with, the community. The following and similar activities are allowed:

- 1) Homemaker activities essential to the consumer’s health care needs to prevent or postpone institutionalization when provided during the provision of other Attendant Care services.
- 2) Assistance, as defined in the Plan of Care as follows: personal care (bathing; partial bathing; oral hygiene; hair care; shaving; hand and foot care; dressing; clipping hair; and application of cosmetics), mobility (proper body mechanics; transfer between bed and chair; and ambulation that does not include assistive devices), elimination (assists with bedpan, bedside commode, toilet; incontinent or involuntary care; and emptying urine collection and colostomy bags), nutrition (meal planning, preparation, clean-up), safety (use of principles of health and safety in relation to self and consumer; identify

and eliminates safety hazards; practice health protection and cleanliness by appropriate techniques of hand washing; and waste disposal and household tasks), medication (reminding consumer to self administer medication), assistance with correspondence and bill paying, escorting individuals to community activities that are therapeutic in nature or that assist with developing/maintaining natural supports.

Attendant Care services must follow a written Plan of Care addressing specific needs determined by the consumer's assessment. Attendant Care services will not be provided to medically unstable consumers as a substitute for care provided by a registered nurse, licensed practical nurse, licensed physician or other health professional

The type of assistance to be provided must be defined in the Plan of Care. Providers of Attendant Care services are to be paid by the Medicaid program for only those services specified in the individual's Plan of Care. Qualifications for providers of Attendant Care are included in the A&D Waiver.

**“Behavioral interventions”** - Those interventions that will modify the consumer's behavior or the consumer's environment.

**“Caregiver”** - Any person responsible for providing care and services to consumers, including the provider; the primary caregiver, and any substitute or caregiver designated to provide care and services to consumers.

**“Care Plan” or “Plan of Care”** - A plan that is written by the case manager, from the comprehensive assessment defined in section 22 of this rule, to establish supports and strategies intended to accomplish the individual's long term and short term goals by accommodating the financial and human resources offered, as well as behavioral-related assistance to the individual through paid provider services or volunteer services, or both, as designed and agreed upon by the individual. (460 IAC 1.1-3-17)

**“Case manager”** – Provides Case Management services to HCBS Medicaid Waiver consumers as described under “Case Management Services”.

**“Case Management Services”**- Case management is the single most important element in accomplishing these goals for clients eligible for Medicaid Waivers. Medicaid Waiver ongoing case managers coordinate and integrate all services required in a client's plan of care, link clients to needed services, and ensure that clients continue to receive and benefit from services. Waiver case managers enable clients to receiver a full



range of services needed because of a medical condition, in a planned, coordinated, efficient, effective manner.

Case management is a comprehensive service comprised of a variety of specific tasks and activities designed to coordinate and integrate all other services required in the client's plan of care. Case management is required in conjunction with the provision of any home and community-based service.

The components of case management are:

- a. Level of Care Assessment
- b. Medicaid eligibility
- c. Plan of Care development
- d. Monitoring
- e. Advocacy on behalf of the consumer

Case Management services for persons who are on a Medicaid Waiver are provided by the FSSA DA certified case managers. The sixteen local AAAs serve as the single point of entry for the Medicaid Waivers that require a Nursing Facility LOC. A case manager from the AAA will be assigned to an applicant. After an applicant has been determined to meet eligibility criteria and approved to receive Medicaid HCBS Waiver services, he or she may choose to retain their current AAA case manager or choose a non-AAA or independent case manager, for on-going Case Management Services.

**“Certification Standards”** - The specific AFC service standards established for all consumers and providers who participate in any of the Medicaid HCBS Waiver Programs for persons who are aged or medically disabled.

**“Chemical Restraint”** – Use of any chemical method used to restrict the consumer's activities and behavior.

**“Choice”** - A consumer has viable options that enable him/her to exercise greater control over his/her life. Choice is supported by the provision of sufficient private and common space within the home to provide opportunities for consumers to select where and how to spend time and receive personal assistance.

**“Complaint”** - An allegation that a provider has violated these Certification Standards, dissatisfaction relating to the condition of the AFC home or the consumer(s), or any situation in which the consumer feels his/her rights have been substantially violated by the provider.

**“Consumer”** -An individual who is eligible for the FSSA Waiver Services HCBS Medicaid Waiver Program, and receives those services in a AFC

home; a person living in an AFC setting for whom the service of AFC is paid through the FSSA Waiver Services HCBS Medicaid Waiver Program. "Consumer" includes former consumers when examining complaints about admissions, re-admissions, transfers or discharges. For decision-making purposes, the term "consumer" includes the consumer's surrogate decision-maker in accordance with State law or at the consumer's request.

**"Consumer Contract"** - An agreement or contract completed by the AFC services provider for each potential consumer that includes: a description of the services to be provided to the consumer; a description of the contract modification process; a description of the complaint resolution process; specific "House Rules"; and other general information.

**"Consumer Rights" or "Rights"** - Those rights as defined in these Certification Standards, and the rights of citizenship that cannot be preempted by this rule, certification standards, or any other aspect of services provided in an AFC setting.

**"Consumer Risk Contract"**- This contract will be initiated by the provider for each consumer, and will address unusual situations in which a consumer's assertion of a right, behavior, or preference exposes the consumer or someone else in the home to a real and substantial risk of injury. The Consumer Risk Plan will identify and accommodate a consumer's need in a way that is acceptable to the provider, primary caregiver, and consumer. It will include an explanation of the cause(s) of concern; the possible negative consequences to the consumer and/or others; a description of the consumer's preferences; possible alternatives or interventions to minimize the potential risks associated with the consumer's preferences/action; a description of the AFC services that the provider will provide in order to accommodate the consumer's choice or to minimize the potential risk and services other entities will provide to accommodate for their choice or to minimize this risk; final agreement reached by all parties. A Consumer Risk Contract cannot, however, preempt or curtail the consumer's rights as a citizen.

**"DDRS"**- Department of Disabled, and Rehabilitation Services, a division within FSSA in which the Bureau of Quality Improvement Services (BQIS) is located.

**"Dignity"** - Providing support in such a way as to validate the self-worth of the individual. Dignity is supported by designing a structure that allows personal assistance to be provided in privacy and delivering services in a manner that shows courtesy and respect.

**"Elderly" or "Aged"** - Any person age 65 or older who is in need of care.

**“FSSA Waiver Services”**- The division within the FSSA DA under which the HCBS Medicaid Waiver Program is administered. For purposes of this document, FSSA Waiver Services may also include any designee providing oversight and/or collaboration regarding the provision of AFC service under the A&D Waiver. This may include other Bureaus under DDRS, OMPP, the FSSA DA, or may include contractors or other entities to which FSSA Waiver Service duties have been formally delegated.

**“HCBS Medicaid Waiver Provider Agreement”** - A provider agreement signed by an AFC provider who is enrolled in the HCBS Medicaid Waiver Program.

**“Home”** - The physical structure in which up to three consumers and their caregiver live, synonymous with AFC services.

**“Homelike”** - An environment that has the qualities of a home, including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences, which promotes the dignity, security and comfort of consumers through the provision of personalized care and services to encourage independence, choice, and decision-making by the consumers. A homelike environment also provides consumers with an opportunity for self-expression, and encourages interaction with the community, family and friends.

**“House Rules”** - Written rules managing or organizing home activities in an AFC home which are developed by the provider and/or primary caregiver, and approved by the FSSA Waiver Services HCBS Medicaid Waiver Program. These might include “non-smoking home”, etc. House rules cannot be so restrictive as to interfere with a citizen's rights under State and Federal law.

**“Independence”** - Free from the control of others and being able to assert one's own will, personality and preferences within the parameters of the house rules or consumer agreement.

**“Level of Service”** - The specific level of service that the provider is authorized to provide in accordance with the consumer's plan of care and based on the assessed impairment level of the consumer.

**“Level of Service Assessment” or “Level of Service Assessment Tool”** - The assessment instrument that is utilized to determine the appropriate level of service to be provided and paid according to three (3) impairment levels, with level 1 being the least impaired/most independent and level 3 being the most impaired/least independent. The tool is specifically intended to evaluate the consumer's needs in the areas of: expressive and receptive communication; orientation; adaptation to change; judgment; memory; awareness of own needs; behavior, wandering, night needs, feeding and nutrition, transferring,

dressing/undressing; bathing; personal hygiene; toileting; bladder and bowel control; mobility; medication and treatment procedures. It shall include interviews with the prospective consumer, his/her family and prior care providers, as well as any physician, nurse practitioner, RN, pharmacist, therapist or other health/mental health professional involved in the care of the consumer.

**“Medical Emergency”** - A change in the consumer’s medical condition that requires immediate care of a level or type that the provider is unable to provide or behavior that poses an imminent danger to the consumer or to other consumers or people living in the home.

**“Medically Disabled” or “Disabled”** - A person who is 18 years of age or older with a physical, cognitive, or emotional impairment which, for the individual, constitutes or results in a functional limitation in activities of daily living. The individual must meet Nursing Facility LOC to obtain AFC services.

**“Medication Management”** - The provision of reminders or cues, the opening of pre-set commercial medication containers, and/or providing assistance in the handling or ingesting of medication that is not a controlled substance. Provision of medication management services shall be at the direction of a consumer who is competent, but otherwise unable to accomplish the task him/herself due to an impairment or physical infirmity. In the event a consumer is not competent, or in instances where competence is in question, a competent individual who is responsible for the health and care of the consumer may direct the appropriate assistance for the consumer. For purposes of this definition, “medication” means prescription medications.

**“Occupant”** - Anyone residing in or using the facilities of the AFC home including consumers, providers, primary caregivers, substitute caregivers, or family members.

**“OMPP”** - The Office of Medicaid Policy and Planning within FSSA.

**“Ombudsman”** - A representative of the office of the State Long Term Care Ombudsman who serves as an advocate for consumers, with responsibilities that include investigation and resolution of complaints on behalf of consumers of AFC services.

**“Physical Restraint”** - Any manual method or physical or mechanical device, material, or equipment attached to, or adjacent to, the consumer’s body which the consumer cannot easily remove and restricts freedom of movement or normal access to his/her body. Physical restraints include, but are not limited to, leg restraints, soft ties or vests, hand mitts, wheelchair safety bars, lap trays, any chair that prevents rising, and gerichairs. Side rails (bed rails) are considered restraints when they are

used to prevent a consumer from getting out of a bed. When a consumer requests a side rail (e.g. for the purpose of assisting with turning), the side rail is not considered a restraint. Chemical and physical restraints are barred from use in the AFC home under this rule.

**“Plan of Care” or “Care Plan” or “Individual Plan of Care”** - The written plan developed by the case manager, provider, and consumer or others on consumer's behalf, in which the case manager documents the proposed AFC service, the Medicaid State Plan Services, as well as other medical services and social services and informal community supports that are needed by the consumer to ensure his/her health and welfare. The initial Plan of Care must be approved by the FSSA Waiver Services waiver specialist prior to the initiation of Medicaid-funded Waiver Services. The Plan of Care must be reviewed and updated as needed but no less often than every ninety (90) days for each AFC consumer, regardless of Service Level.

**“Primary Caregiver”**-The person with whom the consumer resides, and who provides AFC services to the consumer on a regular basis, under the jurisdiction of the FSSA Waiver Services HCBS Medicaid Waiver Program. This person may be, but is not required to be the provider. In homes in which the primary caregiver is not the provider; he or she is a contracted employee of that AFC service provider. The primary caregiver is the resident manager of AFC services for each consumer residing in that AFC home.

**“Provider”** - An individual, partnership, corporation, or other entity, which enters into an agreement with FSSA Waiver Services HCBS Medicaid Waiver Program to provide AFC services to HCBS Medicaid Waiver Program consumers. “Provider” means the person(s) responsible for the provision of room, board, care and services in the daily operation of the home. Provider may be, but is not required to be, the primary caretaker.

**“Psychoactive Medications”** - Various medications used to alter mood, anxiety, behavior or cognitive processes. For the purpose of these Certification Standards, they include, but are not limited to, anti-psychotics, sedatives, hypnotics, and anti-anxiety medications.

**“Reside”** - For a person to make the AFC home his/her permanent residence.

**“Room and Board”** - The provision of meals, a place to sleep, laundry and housekeeping.

**“Self-Administration of Medication”** - The act of a consumer placing a medication in or on his/her own body. This means the consumer manages and takes his or her own medications, in that the consumer identifies the medication and the times and manners of administration, and places the

medication internally or externally on his/her own body without assistance. This may include reminders, cues, and/or opening of medication containers by caregiver when requested by a consumer. Assistance with prescription eye drops is not allowed, and would need to be self administered.

**“Self-Preservation”** - In relation to private residence fire and life safety means the ability of consumer to respond to an alarm without additional cues and to be able to reach a point of safety on their own.

**“Substitute Caregiver”** - Any person who provides AFC services in an AFC home, under the jurisdiction FSSA Waiver Services HCBS Medicaid Waiver Program, other than the provider or primary caregiver. This person is subcontracted by the provider to provide this service.

## **II. Provider Requirements**

### **A. Provider Eligibility and Enrollment**

The AFC service provider must follow the current procedures of provider application and eligibility determination as prescribed by FSSA DA or a FSSA DA designee. All steps must be followed and documented, and all standards required for Medicaid Waiver Provider status must be met in order to obtain certification. The burden of proof shall be upon the provider to establish compliance with the Certification Standards.

AFC providers are individuals who are willing to share their home and family life with up to three eligible disabled or elderly persons. The provider cannot be the parent of a minor child, the spouse, or other relative by blood or marriage of the consumer. The provider must be at least 21 years of age, and must live in a setting that is suitable for provider and consumer(s). The provider must be physically and mentally able to provide care for the consumer, according to the Plan of Service.

An AFC home provider shall live in the home that is to be enrolled, unless another provider-contracted primary caregiver lives in the home in the provider's stead. If the primary caregiver is not the provider, the same qualifications are required for that caregiver as those required for the provider, with the understanding that the liability insurance, safety provisions, and financial assurances are the responsibility of the provider. Caregivers other than the provider will be subcontractors of the provider, and it will be the responsibility of the provider to ensure the state that these caregivers meet the same eligibility requirements. Documentation should be kept in a provider's file, and should be available to FSSA Waiver Services or designee at any point in the certification and ongoing monitoring process of that home.

An AFC home provider must have a statement from a physician or other qualified practitioner indicating the provider and/or primary caregiver are free from TB and other communicable diseases. There must be documentation of annual physicals for all caregivers. Provider must be physically, cognitively, and emotionally capable of providing care to consumer. The provider is required to pass a criminal background check. The AFC provider must have the ability to provide services for consumers in a manner and in an environment that encourages maintenance or enhancement of each consumer's quality of life, and promotes the consumer's privacy, dignity, choice, independence, individuality, and decision-making ability.

If there is a documented history or substantial evidence of a substance abuse or mental illness, provider must provide evidence satisfactory to FSSA Waiver Services or designee of successful treatment and rehabilitation.

An AFC provider must be literate and demonstrate the understanding of written and oral orders and the ability to communicate with consumers, physician, case manager, and appropriate others; and be able to respond appropriately to emergency situations at all times.

An AFC provider must have a clear understanding of job responsibilities, have knowledge of consumer's care plans and be able to provide or obtain the care specified for each consumer's needs.

The provider must provide assurances to FSSA Waiver Services or designee of reliable back up for those times when the primary caregiver must be absent from the home. The provider must designate specific substitute caregivers who will meet caregiver qualifications, and be available for those absences (when one consumer needs to be taken to a medical appointment, etc.) The enrollment application must include a written plan on coverage for primary caregiver absences. The use of substitute caregivers must include assurances that the substitutes meet eligibility requirements of caregiver.

FSSA Waiver Services or designee may deny an application for noncompliance with any such requirements.

In addition, the enrollment application for providers of AFC services shall include the following information be submitted by the provider applicant:

1. The maximum consumer capacity requested and the number of any other occupants, which is not to exceed 3 consumers;
2. The service level classification being requested with information and supporting documentation regarding qualifications, relevant work experience, and training of all caregivers as required by FSSA Waiver Services or designee;
3. A floor plan of the house showing location and size of rooms, exits, wheelchair ramps if applicable, smoke detectors and extinguishers. The floor plan shall show exits and directions for vacating the premises;
4. A list of three reliable references, at least three of whom must be non-relatives that have current knowledge of the provider-applicant's character and capabilities;
5. A written plan describing the planned operation of the AFC home, including the use of primary caregivers other than the provider, and substitute caregivers;
6. A certificate of CPR/First Aid training;
7. A criminal background check;
8. A document from a physician indicated that the provider is free of TB;
9. An annual physical.

#### **B. Certification of AFC Provider and Home**

An on site review of the home will be completed in order to assess the provider's ability to safely and successfully provide AFC care of the consumer. FSSA



Waiver Services or designee will certify that the following criteria are met during this initial certification inspection.

On-site provider files that document that all provider requirements are met. (i.e.: liability insurance, current annual physical exam, etc.) will be present, and available for review by inspector.

The inspector, designated by FSSA Waiver Services, will do a home inspection to assure that all required standards are met in the physical home. There will be documents to verify standards are met for criteria not visible to inspector.

Each AFC home shall meet all applicable local zoning, building and housing codes, and state and local fire and safety regulations for a single family residence. The building and furnishings shall be clean and in good repair. Grounds shall be well maintained. Walls, ceilings, and floors shall be of such character to permit frequent washing, cleaning, or painting. There shall be no accumulation of garbage, debris, rubbish or offensive odors.

AFC homes shall meet all applicable state and local building, mechanical, and housing codes for private residence fire and life safety. At least one working fire extinguisher shall be in a visible and readily accessible location on each floor, including basements, and shall be inspected at least once a year. Fire extinguishers shall be tagged, with a signature and date of inspection.

All consumers shall have unobstructed passageways throughout the house. Interior and exterior stairways shall be provided with handrails. Adequate lighting, based on the needs of the individual, shall be provided in each room, stairway, and exit-way. Incandescent light bulbs shall be protected with appropriate covers. Yard approved exits and exterior steps shall be accessible and appropriate to the condition of the consumers.

The heating and cooling systems shall be in working order. Areas of the home used by consumers shall be properly ventilated and maintained at a safe and comfortable temperature. Heating in accordance with manufacturer's specifications and electrical equipment, including wood stoves, shall be installed in accordance with all applicable private residence fire and life safety codes. Such equipment shall be used and maintained properly and be in good repair.

All exit doors and interior doors shall have simple hardware that cannot be locked against exit without an obvious method of operation, and which does not require a key when locked against exit.

All common use areas of the house and exits must be barrier free and corridors and hallways shall be wide enough to accommodate a walker or wheelchair. Any bedroom window identified as an exit shall be free of any obstacles, at least the width of the window, which would interfere with it being an exit. There shall be a wheelchair ramp from a minimum of one exterior door if non-ambulatory persons are in residence. Wheelchair ramps shall meet the standards of the Americans

with Disabilities Act. Providers may need to bring existing ramps into revised compliance if necessary to meet the needs of new consumers or current consumers with increased care needs. There shall be non-skid backing on throw/scatter rugs, grab bars in bathtub or shower, suitable bedrooms with linens, closets, and drawer space for each consumer.

There shall be current readily available basic first-aid supplies and a first-aid manual.

A public water supply shall be utilized if available. If a non-municipal water source is used, minimum water quality standards must be met.

Septic tanks or other non-municipal sewage disposal system shall be in good working order. Commodes shall be emptied frequently and incontinence garments will be disposed of in closed containers.

Garbage and refuse shall be suitably stored in clean, rodent-proof, covered containers, pending weekly removal.

Prior to laundering, soiled linens and clothing shall be stored in closed containers in an area separate from food storage, kitchen and dining areas. Special pre-wash attention shall be given to soiled and wet bed linens.

Sanitation for household pets and other domestic animals shall be adequate to prevent health hazards. Proof of rabies or other vaccinations required by a certified veterinarian shall be maintained on the premises for household pets. Pets not confined in enclosures must be under control and must not present a danger to consumers or guests.

There must be adequate control of insects and rodents including screens on doors and windows that are used for ventilation.

Universal precautions for infection control should be followed in consumer care. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with blood or other body fluids.

Bathroom specifications: The Consumers bathroom must provide individual privacy and have a finished interior, with a mirror; a functioning window or other means of ventilation; and a window covering. The rooms must be clean and free of objectionable odors. There will be tubs or showers, toilets and sinks in good repair.

Bathrooms must have hot and cold water at each tub, shower, and sink in sufficient supply to meet the needs of the consumers. Hot water temperature in bathing areas shall be supervised for persons unable to regulate water temperature. Shower curtains and doors shall be clean and in good condition. Non-slip floor surfaces shall be provided in tubs and showers.

There must be safe and secure grab bars for toilets, tubs, and/or showers for consumer's safety. Bathrooms must have adequate supplies of toilet paper and soap. Consumers will be provided with individual towels and washcloths, which are laundered in hot water at least weekly or more often if necessary. There will be appropriate racks or hooks for drying bath linens.

Bedroom specifications: Providers, caregivers, or their family members shall not share bedrooms with consumers. All consumers will have a private room unless the consumer insists on another arrangement. Each will be provided an individual bed that consists of a mattress and springs, or equivalent, in good condition. Cots, rollaway mattresses, bunks, trundle, daybeds with restricted access, couches, and folding beds may not be used for consumers. Daybeds with good access may be used if this is the consumer's choice. Each bed shall have clean bedding in good condition consisting of a bedspread, mattress pad, two sheets, a pillow, a pillowcase, and blankets adequate for the weather. Sheets and pillowcases shall be laundered at least weekly, and more often if soiled. Waterproof mattress covers must be used for incontinent consumers. Each bedroom shall have sufficient space for each consumer's clothing and personal effects including hygiene and grooming supplies, and consumers will be allowed to keep and use reasonable amounts of personal belongings and have private, secure storage space. Drapes or shades for windows shall be in good condition and allow privacy for consumers.

Bedrooms shall be on ground level for consumers who are non-ambulatory, have impaired mobility, or are cognitively impaired. Consumers on the second floor or in the basement must demonstrate their self-preservation capability to self-exit or barricade, i.e., close the door or stop smoke from coming under the door. Bedrooms will have at least one window or exterior door that can be readily opened from the inside without special tools and which provides a clear opening

Meal specifications: Three regularly scheduled, nutritious meals must be offered daily. Nutritious snacks and liquids should be available and offered to fulfill each consumer's nutritional requirements. Special consideration must be given to consumers with chewing difficulties and other eating limitations. Food shall not be used as an inducement to control the behavior of a consumer. Special diets are to be followed as prescribed in writing by the consumer's physician/nurse practitioner. Food should be stored and maintained at the correct temperature in a properly functioning refrigerator. Utensils, dishes and glassware shall be washed by dishwasher or by hand in hot soapy water, rinsed, and stored to prevent contamination.

Communication: A telephone should be provided in the home and made available and accessible for consumers' use in a location that allows for a reasonable amount of privacy for incoming and outgoing calls. Consumers with hearing impairments (to the extent that they cannot hear over a normal phone) will be provided with a telephone that is amplified with a volume control or is hearing aid compatible. The telephone number must be a listed number. Emergency telephone numbers shall be posted by the telephone including an emergency number to reach a provider who does not live in the home.

Telephone numbers for the State Ombudsman and the local ombudsman must also be posted.

**Safety requirements:** The following universal safety requirements will be followed in addition to the individual specifications outlined in a consumer's Consumer Risk Management Contract. This contract will be initiated by the provider for each consumer, and will address situations in which a consumer's assertion of a right, behavior, or preference exposes the consumer or someone else in the home to a real and substantial risk of injury. The Consumer Risk Plan will identify and accommodate a consumer's need in a way that is acceptable to the provider, primary caregiver, and consumer. It will include an explanation of the cause(s) of concern; the possible negative consequences to the consumer and/or others; a description of the consumer's preferences; possible alternatives or interventions to minimize the potential risks associated with the consumer's preferences/action; a description of the AFC services that the provider will provide in order to accommodate the consumer's choice and/or to eliminate the potential risk, as well as services other entities will provide to accommodate for their choice or to minimize this risk; and final agreement reached by all parties. The provider will involve and satisfy the consumer, the case manager, and others involved in consumer's care in the development implementation, and review of the risk assessment.

Smoke detectors shall be installed in accordance with the manufacturer's listing and be installed in each bedroom, in hallways or access areas that adjoin bedrooms, family room or main living area where consumers congregate, any interior designated smoking area, and in basements. In addition, in two-story houses, smoke detectors must be installed at the top of the stairway to the second floor. Ceiling placement of smoke detectors is recommended. Detectors shall be equipped with a device that warns of low battery when battery operated or with a battery backup if hard wired. All smoke detectors are to be maintained in functional condition. Battery-operated smoke detectors must be tested monthly and batteries changed at least once per year. Bedrooms used by hearing-impaired occupants who cannot hear a regular smoke alarm must be equipped with a visual/audio or vibration alerting smoke alarm as appropriate.

All smoke detectors shall contain a sounding device or be interconnected to other detectors to provide, when actuated, an alarm that is audible in all sleeping rooms.

**Hazardous Materials:** Flammable and combustible liquids and hazardous materials shall be safely and properly stored in original, properly labeled containers or safety containers and secured in areas to prevent tampering by consumers or vandals. Cleaning supplies, medical sharps containers, poisons and insecticides shall be properly stored in original, properly labeled containers in a safe area away from food preparation and storage areas, dining areas, and medications. Any firearms owned by the primary caregiver must be stored, unloaded, in a locked cabinet. The firearms cabinet must be located in an area of

the home that is not accessible to consumers. Consumers are not allowed to bring firearms into the home, and it should be noted that a provider is also highly discouraged from keeping firearms on the premises as well. When firearms are present, this fact should always be addressed in the Consumer Contract, for benefit of consumer awareness. Any firearm accidents that would occur would be the responsibility of the provider.

Fire evacuation: An emergency evacuation plan shall be developed, posted and rehearsed with occupants. All caregivers shall be required to demonstrate the ability to quickly evacuate all consumers from the home to the closest point of safety, which is exterior to, and away from the structure. If there are problems in demonstrating this evacuation time, conditions may be applied to the HCBS Medicaid Waiver Provider Agreement that include, but are not limited to, reduction of consumers under care, or increased fire protection. Within 24 hours of arrival, any new consumer or caregiver will be shown how to respond to a fire alarm, shown how to evacuate from the home in an emergency, and receive an orientation to basic fire safety. The provider will provide, keep updated and post a floor plan containing room sizes, location of each consumer's bedroom, fire exits, caregiver's sleeping room, smoke detectors and fire extinguishers. A copy of this drawing will be submitted with the application and updated to reflect any change. There must be a second safe means of egress. Providers whose sleeping rooms are above the first floor may be required to demonstrate a fire exit drill from that room, using the secondary egress, at the time of enrollment, renewal, and/or inspection. There will be at least one plug-in rechargeable flashlight available on each floor for emergency lighting that is checked on a monthly basis. Smoking regulations will be adopted to allow smoking only in designated areas. Smoking will be prohibited in sleeping rooms, homes where oxygen is used, or in garages where flammable materials are stored. Ashtrays of noncombustible material and safe design shall be provided in areas where smoking is permitted.

#### C. Required Documentation for Provider Maintained Files

The provider must maintain a file that includes copies of all the documentation required for the provider enrollment and certification process, as well as the documentation to substantiate that these requirements are maintained. These will include, but are not limited to fire inspection, emergency plans and contact numbers, training certifications for all caregivers, Medicaid Provider Agreement, insurance documentation, and required health and safety records. In addition, the provider will maintain current and comprehensive consumer files.

The provider must create and maintain a personal file for each consumer. This file must include all prudent, personal information about consumer, including but not limited to: name, date of birth, social security number, family contact, medical information, current Plan of Care, and documentation of all reported incidents

involving the health of the consumer. The provider is to be aware and understand all privacy and Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations concerning consumer's records and information. There will also included in this file documentation which indicates whether or not a consumer has Advance Directives, Living Will, Power of Attorney, Health Care Representative, Do Not Resuscitate (DNR) Order, or Letter of Guardianship, if these documents exist, copies must be present in the file.

The provider is required to document a consumer progress/status note at least once every seven days.

The provider shall place a copy of the Individual Plan of Care in the consumer's file.

Consumer files for HCBS Medicaid Waiver Program consumers maintained by the provider shall be readily available at the AFC home for all caregivers and to representatives of FSSA Waiver Services or designee conducting inspections or investigations, as well as to consumers, their authorized representative or other legally authorized persons. The ombudsman has access to all consumer and home files.

Information related to consumer(s) shall be kept confidential, except as may be necessary in the planning or provision of care or medical treatment, or related to an investigation or sanction action under these standards.

Consumer financial records: If the provider manages or handles a consumer's money, a separate account record shall be maintained in the consumer's name. The provider shall not under any circumstances commingle, borrow from, or pledge any funds of a consumer. Personal Needs Allowance (PNA) for an HCBS Medicaid Waiver consumer is to be used at the discretion of the consumer. Providers or caregivers shall not influence, solicit from or suggest to any consumer that they or their family give the caregiver or the caregiver's family money or property for any purpose. The provider/caregiver or the caregiver's family shall not accept gifts of substantial value or loans from the consumer or the consumer's family.

Providers shall maintain the following financial records on the premises with the home records: Agreements with FSSA Waiver Services or designee, consumer, relatives, or person(s) paying for care, with any financial planning sheets prescribed by FSSA Waiver Services or designee if pertinent, and consumer account record, as prescribed by FSSA Waiver Services or designee, of expenditures if the provider manages or handles a consumer's money. The record must show amounts and sources of funds received and issued to, or on behalf of, the consumer. Any purchases made on behalf of a consumer, must be documented by receipts.

The provider shall maintain liability insurance of at least one hundred thousand dollars per occurrence to cover damage or loss of the consumer's property if due to negligence of the insured or injury or harm to the consumer resulting from the provision of services or failure to provide needed services and incidents occurring in the AFC home or on the home's premises.

**Consumer Contract:** Prior to admission, the AFC services provider must complete a Consumer Contract with each potential consumer or his/her designated representative. The contract must cover the following topics: name, street address, and mailing address of the AFC home. The term of the contract, a description of the services to be provided to the consumer, a description of additional services provided outside of the Waiver Program, but for which provider may assist in by arrangement of appointments or provision of transportation, a description of the process through which the contract may be modified, amended, or terminated, a description of the complaint resolution process available to the consumers, and the name of the consumer's designated representative, if applicable. Also included is specific information related to any house rules, which must not be in conflict with the consumer rights as defined in these standards or the family atmosphere of the home. House rules are subject to review and approval by FSSA Waiver Services or designee prior to HCBS Medicaid Waiver Program enrollment. The consumer contract is to be reviewed annually by case manager, provider, caregiver, and consumer and/or consumer family members.

Consumers shall not be liable for damages considered normal wear and tear. The AFC provider will not include any provision in a consumer agreement or disclosure statement that is in conflict with these standards and guidelines, and shall not ask or require a consumer to waive any of the consumer rights or the facility's liability for negligence. The provider will retain a copy of the signed and dated consumer agreement and provide copies to the consumer or to his/her designated representative and to FSSA Waiver Services or designee upon request.

The AFC provider will ensure that consumers have control over their time, space and lifestyle to the extent that the health, safety and well-being of other consumer is not disturbed; and will promote the consumer's right to exercise decision making and self-determination to the fullest extent possible; and will provide a safe, clean and comfortable homelike environment, allowing consumers to use their personal belongings to the extent possible.

The Consumer Contract will also include statement of consumer rights, to be signed by the provider and consumer. The AFC service provider shall provide a copy of Consumer Rights prior to execution of the consumer contract and provide a copy of the Consumer Rights to anyone requesting a copy. (For additional information regarding Consumer Rights, refer to Section III -C in this document.)

The AFC services provider shall have readily-available a copy of the address and telephone number of the local or state ombudsman program and of the local AAA.

The FSSA DA provider agreement, attached conditions to the agreement if applicable, the Consumer Rights, the floor plan that indicates the fire evacuation route, the house rules, the FSSA Waiver Services or designee inspection form, ombudsman poster, and the FSSA DA or designee procedures for making complaints shall be posted or made readily available to consumer and others.

#### D. Primary and Substitute Caregivers Requirements

It is the AFC provider's responsibility to provide assurances to the state that any subcontractors that are employed in order to provide AFC services meet all caregiver requirements. When the primary caregiver is not the actual provider with whom the Waiver Provider agreement is signed, the provider must maintain in the provider file all necessary documentation. The requirements of, all caregivers, including primary and substitute caregivers will be the same as those for the provider, homeowner and liability insurance and home inspection requirements. The requirements for the safety of the physical dwelling that is the AFC home falls under the responsibilities of the homeowner, who must be the provider.

Primary and substitute caregiver requirements: The primary caregiver will reside their own home or the home owned by the provider. The caregiver's family unit may reside in the home along with the caregiver and the consumers. Just as with the provider, all caregivers must be twenty-one (21) years of age or older and meet all the provider requirements. The provider must ensure that a qualified caregiver is present and available at the home at all times when consumers are in the home. A consumer shall not be left in charge in lieu of a caregiver.

Substitute caregivers, persons other than the provider or primary caregiver, must meet all standards, including but not limited to: documentation of ability to pass a criminal record check, CPR/First Aid training; must be literate and demonstrate the understanding of written and oral orders and the ability to communicate with consumers, physician, case manager, and appropriate others; and be able to respond appropriately to emergency situations. They must have a clear understanding of job responsibilities, have knowledge of consumer's care plans and be able to provide the care specified for each consumer's needs. All caregivers must have an annual physical, including a TB test, and will provide a statement from a physician indicating date of exam and testing and that they are free from TB.

#### E. Training Requirements for all Caregivers



The provider will keep documentation of the training and orientation of primary and substitute caregivers.

All providers, primary and substitute caregivers must complete all training requirements of FSSA Waiver Services or designee. Prior to admission of the first HCBS Medicaid Waiver consumer to the AFC home, and annually thereafter, the provider, primary, and any substitute caregivers must complete a basic first aid course, and cardiopulmonary resuscitation (CPR) course. Documentation of training shall be kept in the facility's records including the date of training, subject matter, name of agency or organization providing training and number of classroom hours.

FSSA Waiver Services or designee may grant an exception to the training requirements established in these Certification Standards for a substitute caregiver who holds a current Indiana license as a health care professional such as a physician, registered nurse, or licensed practical nurse. The requirement for an annual CPR course training shall not be waived.

The provider must orient any substitute caregiver to the home and to the consumers, including location of fire extinguisher; demonstration of evacuation procedures; location of consumer's records; location of telephone numbers for the consumer's physicians, the provider and other emergency contacts; location of medications and key for medication cabinet; introduction to consumers; and instructions for caring for each consumer.

#### **F. Level of Service and Payment**

AFC service will be provided and paid according to these three (3) Levels of Service, with level 1 being the least impaired and level 3 the most impaired/dependent.

The impairment level assessment tool for AFC service will be based on the point system definitions designated on the Level of Service Assessment Tool used for the Assisted Living Waiver.

AFC will provide in home services to those consumers who are determined to meet any of the three care levels, and whose needs can be met in an AFC setting, however, it should be noted that initial eligibility will only allow those with a level 1 or level 2 service need to receive AFC and be admitted to an AFC home environment. Providers may initially be enrolled for AFC service provision only in levels 1 and 2 of service so long as the provider is able to meet these service level requirements. Providers can accept a new consumer into their home only if the consumer is assessed at level 1 or level 2. However, a consumer who is already receiving AFC service in an AFC home at level 1 or level 2 may be found to be eligible to remain in the home after being assessed at a higher level due to worsening condition, provided that the AFC provider has successfully provided

services to this individual when service needs met level 2 criteria, and the provider and the consumer both wish to continue AFC services for this individual in the event of the worsened condition, and the Caregiver and home will meet the additional needs. This will allow the consumer to remain in the community during temporary lapses in health, and to remain in the AFC home for as long as possible with a worsening of their condition. Additional medical training may be required for the AFC provider to maintain the consumer in the home as medical conditions worsen. Consumers will be assessed on a case by case basis during the site visit by the case manager, which would need to be completed for a change in the consumer's Level of Service needs. Safeguards must be in place to ensure that the provider can handle the increased medical issues. In short, the provider must prove their ability to provide the higher level of care that the individual consumer requires.

Providers may only admit or continue to care for consumers whose impairment levels are within the classification level of the home.

A provider may request a change in service level at any time during the year, but must specify the request, and the reason it is desired, in writing. An assessment will be completed when there have been significant changes in condition.

The AFC Assessment Tool used to determine eligibility will be the same tool that is currently used to determine eligibility for the Assisted Living Waiver. Some items may become disqualifiers for admission. (For example, if home is unable to provide a safe environment for a consumer who is an unpredictable elopement risk, etc.) Levels of Service will be designated as levels 1, 2, or 3.

The AFC Assessment Tool will assess consumer's Level of Service needs based on a point system:

- Level 1-Total points fewer than 36
- Level 2-Total points 37-60
- Level 3-Total points 61-75

(For additional information regarding the level of service assessment, refer to Section III.-B within this document.)

Following approval of AFC services and admission to an AFC home, the case manager shall conduct and document a review of the consumer's status on-site at least once every ninety (90) days. Reassessment will occur more frequently as needed as determined by the case manager, caregiver and/or provider. The Level of Service Assessment will be completed and documented as often as necessary, and at minimum, as part of the annual level of care eligibility re-determination process. AFC encourages providers to support a consumer's choice to remain in his or her living environment as long as possible.

An all-inclusive daily base rate for each of the three (3) service levels will be established by OMPP and will be paid to the provider for each HCBS Medicaid

Waiver consumer. Provider payment rates will be based on the level of service a consumer requires. The service payments are for the consumer's care by the provider only and exclude room and board.

The consumer is responsible for his/her room and board. This payment is to be paid directly to the provider by the consumer or his/her guardian. AFC Providers must be willing to accept the current SSI rate (minus the consumer's personal needs allowance) or a Section 8 housing voucher as payment for the consumer's monthly room and board

This AFC service rate will include personal care and services, homemaker, chore, attendant care and companion services, and medication oversight, to the extent permitted under State law. The rate will be considered payment in full for all services provided, except room and board. Separate payment will not be made for homemaker or chore services furnished to an individual receiving AFC services, or for transportation services, since these services are integral to and inherent in the provision of AFC services. For those consumers receiving AFC as a waiver services, the only other waiver service allowed is case management. Consumers will still be eligible to use non-waiver Medicaid PA services while receiving the AFC service.

Each consumer is responsible for payment of the room and board services. These are defined and updated according to the room and board definition and amounts prescribed by the Social Security Administration.

#### G. Care and Service Standards

Any services performed under the HCBS Medicaid Waiver Programs for persons who are aged or medically disabled must comply with the prohibitions regarding the practice of medicine under IC 25-22.5-1.

Providers, with the assistance of the case manager and consumer, must create and make readily accessible to the consumer and caregiver a calendar for the consumer which will include scheduled activities, all medical appointments and other services, and medication chart, if indicated.

The AFC Service will include the provision of personal care and services, homemaker, chore, attendant care and companion services, and medication oversight, to the extent permitted under State law. In addition, the consumer may require assistance in the following areas: social and recreational programming, help with eating; dressing; grooming and personal hygiene; bowel and bladder care (incontinence); walking; getting in/out of bed; getting in/out of seating; medical appointments; and transportation. Providers must be able to provide or arrange for appropriate, safe and reasonable consumer transportation requests for community and social activities that are therapeutic in nature or that assist in maintaining or developing natural supports. Providers will see that consumers have appropriate, safe and reasonable transportation for all medical

appointments. There is no reimbursement for travel, as this is a part of AFC service provision. If transportation requests from the consumer or consumer's family supercede what the caregiver/provider deems appropriate, this issue may be discussed with the Waiver Service case manager, and this issue may need to be addressed in the Consumer Agreement.

Other services as specified by the Plan of Care in order to substitute for the absence, loss, or impairment of a physical or cognitive function may also fall under the provision of AFC.

These are to be provided in a FSSA Waiver Services HCBS Medicaid Waiver Program certified private home by a caregiver who lives in the home. This service requires 24-hour caregiver to be on-site in order to meet scheduled and unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

The caregiver shall provide, arrange, or make available three well planned meals per day, seven days per week that provide a balanced distribution of the daily nutritional requirements. The caregiver must offer to provide meals in consideration of food allergies, modified diets as prescribed by the attending physician, and reasonable religious, ethnic, and personal preferences. Food will be served at safe and appropriate temperatures.

Medications, treatments and therapies: The provider and caregivers shall demonstrate an understanding of each consumer's medication administration regimen, including the reason for which the medication is used, medication actions, specific instructions and common side effects.

The provider shall obtain and place a written, signed order in the consumer's record for any medications that have been prescribed by the physician/nurse practitioner. Orders must be carried out as prescribed unless the consumer or the consumer's legal representative refuses to consent. Changes may not be made without a physician/nurse practitioner's order and the physician/nurse practitioner must be notified if a consumer refuses to consent to an order. Order changes obtained by telephone must be documented by filing the pharmacy receipt detailing specifics regarding the prescription. Over-the-counter medication requested by the consumer must be addressed in the plan of care, and must reviewed by the consumer's physician, nurse practitioner, or pharmacist as part of developing the care plan and at time of care plan review.

Prescription medications ordered to be given "as needed" or "p.r.n." must have additional directions which show what the medication is for and specifically when, how much and how often it may be administered. These written directions may be given by a physician, nurse practitioner, registered nurse, or pharmacist:

Self-medication: Consumers must have a physician/nurse practitioner's written order of approval to self-medicate. Persons able to handle their own medical regimen will keep medications in their own room in a small storage area that can

be locked. The provider will notify the physician/nurse practitioner should the consumer show signs of no longer being able to self-medicate safely. Each consumer's medication container will be clearly labeled with the pharmacist's label or be in the original labeled container or bubble pack and shall be kept by consumer or by primary caregiver, depending on individual's need and abilities. If consumers manage their own medicine regimen, caregivers must be well informed of medication management in order that assistance, when needed, is provided. Both caregiver and consumer must have ready access to consumer's medications, but consumers must not have access to medications of the provider or other household members, nor do individuals, other than the caregiver, have access to each consumer's locked medication. Over-the-counter medications in stock bottles (with original labels) may be used in the home. Unused, outdated or discontinued medications must not be kept in the home and will be disposed of according to the pharmacist's recommendations. Disposal of medications will be documented on the medication administration record or in the consumer's record.

For some consumers, it will be necessary that the provider oversees the consumer's medicine intake. The provider may set up each consumer's medications for up to seven days in advance (excluding p.r.n. medications) by using a closed container manufactured for that purpose. If used, each consumer will have her/his own container with compartments for the days and times of the day the medications are to be given. The container must be clearly labeled with the consumer's name, name of each medication, time to be given, dosage, amount, route (if other than oral) and description of the medications.

With consumers who require this level of assistance with their medication, a current, written medication administration record shall be kept for each consumer and shall identify all of the medications administered by the caregiver to the consumer, including over-the-counter medications and prescribed dietary supplements. The document record will indicate the medication name, dosage, route (if other than oral), and the date and time to be given. It will also include a signature of caregiver providing assistance. A suggested format is provided by FSSA Waiver Services (See appendix A)

A discontinued or changed medication order will be marked and dated on the medication administration record as discontinued. The new order will be written on a new line showing the date of order. If a consumer misses or refuses a medication, treatment or therapy the initials must be circled and a brief but complete explanation must be recorded on the back of the medication record. As needed (p.r.n.) medication shall be documented with the time, dose, the reason the medication was given, and the outcome.

Standards for psychoactive medications: Providers will not request a psychoactive medication to treat a consumer's behavioral symptoms without a consultation from the physician, nurse practitioner, registered nurse or mental health professional. The consultation will include a discussion of alternative measures to medication use including behavioral interventions. These

medications may be used only after documenting all other alternative considerations and only when required to treat a consumer's medical symptoms or to maximize a consumer's physical functioning. Psychoactive medications will never be given to discipline a consumer or for the convenience of the AFC home. Psychoactive medications as defined in these Certification Standards may be used only pursuant to a prescription that specifies the circumstances, dosage and duration of use. The provider and all caregivers will know the specific reasons for the use of the psychoactive medication for an individual consumer, the common side effects and when to contact the physician, nurse practitioner, or mental health professional regarding those side effects. All caregivers shall also know the behavioral interventions to be used along with the medication; and the individual completing the initial assessment shall determine the frequency of the reassessment of the psychoactive medication use. The medication usage is included as part of that consumer's individual plan of care, and includes other environmental and behavioral strategies/modifications to address any behavioral symptoms for which the psychopharmacological medication has been prescribed. Prior to making a request to prescribe or increase psychoactive drugs, other accepted interventions must be attempted, if possible, and documented. Information regarding resources is available from the ombudsman. Any change in medication will only occur when the prescribing physician determines it is medically warranted for the consumer.

The consumer shall be free from chemical restraint at all times. In addition, involuntary seclusion can only be used to prevent the spread of infection as ordered by a physician for a medical diagnosis. Physical restraint is not allowed in an AFC home. If consumer loss of control warrants this level of restraint, caregiver should call for emergency assistance.

Care and supervision of consumer will be in a home-like atmosphere and will be appropriate to the needs, preferences, age and condition of the individual consumer. The training of the provider or staff will be appropriate to the age, care needs and condition of the consumers. If a consumer has a medical regimen or personal care plan prescribed by a licensed health care professional, the provider shall cooperate with the plan and ensure that it is implemented as instructed.

The provider is responsible for promptly informing the consumer's physician/nurse practitioner, family, legal representative and case manager of changes in the health status of the individual. Changes in the consumer's condition shall be documented and appropriate medical assistance obtained.

In the event of a serious medical emergency, the caregiver will call 911 or the appropriate emergency number for their community. The physician/nurse practitioner, family or consumer representative and the case manager (when applicable) shall also be called. The provider will have copies of Advance Directives, DNR orders and/or pertinent medical information available when emergency personnel arrive.

Providers will exercise reasonable precautions against any conditions that could threaten the health, or welfare of consumers. A caregiver must be present and available at the home at all times when consumers are in the home, and a consumer cannot be left in charge in lieu of a caregiver.

Providers shall make available activities each week that are of interest to the consumers. Activities shall be oriented to individual preferences as indicated in the consumer's care plan. Documentation of consumer activity participation should be recorded in the weekly status update in the consumer's file. Again, reasonable and unreasonable consumer expectations may need to be addressed in the consumer contract on a case by case basis.

Providers or caregivers must be directly involved with consumers on a daily basis. The physical characteristics of the AFC home should encourage contact between caregivers and consumers and among consumers.

A provider is responsible for the supervision, training and overall conduct of caregivers when acting within the scope of their role in AFC service provision, or when present in the home.

Consumer moves, transfers, and discharges: A consumer may not be involuntarily moved from the AFC home, or to another room within the home, or transferred to another AFC home for a temporary stay without 30 days' written notice to the consumer regarding the consumer move, transfer or discharge. The notification should be provided on a form to the HCBS Medicaid Waiver case manager, the consumer's legal representative, guardian, and the ombudsman. The notice shall state the reasons for the move or transfer and the consumer's right to object to the move or transfer.

Exceptions include situations in which undue delay might jeopardize the health, safety or well-being of the consumer or others, and are outlined in the Aging Rule and the FSSA DA Provider Agreement.

Consumers may be moved or transferred involuntarily without the 30 day notice from the provider for the following reasons:

1. Medical emergencies
2. Behavior which poses an imminent danger or harm to self, others or caregivers
3. Loss of eligibility for the HCBS Medicaid Waiver Program
4. The consumer's care needs exceed the ability (taking into account the provider's own health) or classification of the provider
5. The provider has had the HCBS Medicaid Waiver Provider Agreement revoked, not renewed, or voluntarily surrendered

If the consumer has a medical emergency and/or needs to be admitted to a hospital, the provider must notify the consumer's physician and case manager as

soon as reasonable in order to make the necessary arrangements for the provision of on-going care.

A consumer that is to be involuntarily transferred, or refused the right of return or readmission, may appeal the determination under 405 IAC 1.1.

#### H. Admission Requirements

Prior to placement, the provider, with the assistance of the case manager, will meet with potential consumers who are interested in residing in the AFC home. The provider and/or primary caregiver makes the final decision on who may live in their home. A congenial match is the key to the success of this program.

The provider must obtain and document general information regarding the consumer. The information shall include names, addresses, and telephone numbers of relatives, significant persons, case managers, and medical/mental health providers. The record shall also include the date of admission, the consumer's social security and medical insurance numbers, birth date, prior residence; hospital preference; and mortuary.

The provider shall also obtain and place in the record any medical information available including history of accidents, illnesses, impairments or mental status that may be pertinent to the consumer's care. Additional histories including the following are encouraged: history of over the counter drug usage, social history.

The provider must ask for copies of the following documents and the provider must document whether or not the consumer has them: Advance Directive, Living Will, Power of Attorney, Health Care Representative, DNR order, or Letters of Guardianship. The copies shall be placed in a prominent place in the consumer file and sent with the consumer when transferred for medical care.

The provider must discuss with the consumer and/or her/his representative the Consumer Rights and written house rules. The discussion shall be documented by having the consumer sign the house rules and the Consumer Rights on a provider created form and this form will be filed in the consumer's file.

During the initial phase following the consumer's admission to the home, the provider shall continue the assessment process, which includes documenting the consumer's preferences and observed or expressed care needs. This information should be presented to the case manager at the 90-day review. The assessment shall include observations of the consumer and the review of information obtained from the screening assessment process.

The provider must promptly report significant changes in the consumer's condition to the HCBS Medicaid Waiver case manager, physician, and consumer and/or family member.



The provider shall not restrict the ability of a consumer to engage in activities away from the AFC services provider regardless of the time, duration, and distance of the activities. Ability to handle independent activities such as going for walks, etc., may vary from one consumer to another and should be addressed in the Consumer Contract.

Except to protect the rights and activities of other consumers and residents, the AFC services provider may not restrict the ability of the consumer to have visitors and to receive family members and guests.

The AFC service provider may not restrict the ability of a consumer to use a home health agency, home health provider, or case management service of the consumer's choice; or require a consumer to use home health services.

The provider must notify FSSA Waiver Services or designee immediately of any primary caregiver changes or issues and work with case manager and FSSA Waiver Services to assure that the consumer will continue to receive the necessary care.

The provider shall provide the range of services required to meet the increasing or changing needs of consumers as they age in place to the maximum extent permitted by these standards.

#### **I. Capacity**

The individuals residing in an AFC Home may include the AFC consumers, the primary caregiver, and those individuals who are related to (considered to be the family unit) of the primary caregiver. The number of consumers permitted to reside in a home will be determined by the ability of the caregivers to meet the care needs of the consumers living in that home. Determination of capacity must include consideration of total household composition including children and relatives requiring care and supervision. The number of caregiver family members will be reviewed by FSSA Waiver Services or designee for the appropriateness of match with the individual consumer's needs. These determinations will be made on a case by case basis. There will be no more than three AFC consumers placed in an AFC home.

### **III. Consumer Eligibility Requirements**

#### **A. Medical and Financial**

The FSSA Waiver Services will determine consumer eligibility based on the determination that the consumer meets Nursing Facility LOC, as well as

Medicaid requirements. Consumers who are eighteen years of age or older and are eligible and approved for the A&D Waiver may be eligible for this service.

#### **B. Assessment Tool for Consumer Screening**

Consumers who seek AFC as a service through the FSSA Waiver Services Medicaid Waiver Program must contact the local AAA to complete the Waiver application. A case manager will be assigned and will complete an eligibility assessment, which will determine if the consumer requires a level of care provided by a nursing facility as found at 405 IAC 1-3-1 and 1-3-2. The Nursing Facility LOC eligibility assessment shall be conducted prior to the start of the HCBS Medicaid Waiver and at least annually thereafter.

Prior to the start of AFC services, the case manager will complete an AFC Level of Service Assessment. The Level of Service Assessment Tool shall assess the consumer's needs in multiple areas, including expressive and receptive communication; orientation; adaptation to change; judgment; memory; awareness of own needs; behavior, wandering, night needs, feeding and nutrition, transferring, dressing/undressing; bathing; personal hygiene; toileting; bladder and bowel control; mobility; and medication/ treatment procedures. The Level of Service Assessment will include interviews with the prospective consumer, his/her family and prior care providers as appropriate. The interviews should also include any physician, nurse practitioner, RN, pharmacist, therapist or other health/mental health professional involved in the care of the consumer. Once complete, a copy of the Level of Service Assessment document will be given to the prospective consumer or his/her representative, and a copy will be placed in the consumer file should the prospective consumer become a resident in the home. The Level of Service Assessment and Individual Plan of Care must be completed prior to the consumer's admission into an AFC home. (For additional information regarding the level of service assessment, refer to Section II-F within this document.)

#### **C. Consumer Rights**

The fundamental rights of individuals are not diminished by virtue of residence in an AFC home. The consumer maintains all citizen rights afforded under State and Federal law. The AFC service provider must respect all rights recognized by law with respect to discrimination, service decisions (including the right to refuse services), freedom from abuse and neglect, privacy, association, and other areas of fundamental rights.

Every consumer receiving services in the AFC setting may contact their local or state ombudsman if they have concerns about the provision of this service. The provider is obligated to make available to the consumer the contact information, including phone number for the ombudsman, as well as for other entities that

may assist in ensuring the ongoing rights of the client are upheld. These may include, but are not limited to police, local AAA office, APS, legal services, etc.

AFC providers must accord the consumers living with them the basic rights enjoyed by all individuals in this state, including but not limited to: freedom from verbal, sexual, physical, emotional, financial and mental abuse; freedom from physical or chemical restraints for the purposes of discipline or convenience, and not required to treat the consumer's medical symptoms; freedom to have records kept confidential and released only with a consumer's consent consistent with State law; and freedom to have a service animal, consistent with the "reasonable accommodations" clause of the Fair Housing Act.

#### **IV. Case Management Responsibilities**

The case manager will make level of care determinations for all applicants for this service. This process will utilize the Eligibility Screen. The 450B Physician Certification for long - term care services must be completed. The physician must indicate that a placement in an AFC home would be a "safe and feasible" placement for the consumer.

An Individual Plan of Care will be developed by the case manager in full cooperation with the consumer/guardian and the provider. This Plan of Care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written Plan of Care/Cost Comparison Budget. The Plan of Care/Cost Comparison Budget will be subject to the approval of the FSSA Waiver Services waiver specialists. Based on the assessment and the authorized plan of care, the Individual Plan of Care will be completed and documented within the initial fourteen (14) day period.

The Individual Plan of Care shall support the principles of dignity, privacy, and choice in decision-making, individuality, and independence.

The Individual Plan of Care shall describe the consumer's capabilities, needs and preferences, and shall define the division of responsibility in the implementation of services.

The Individual Plan of Care must address, at a minimum, the following elements: assessed health care needs; social needs and preferences; personal care tasks; and if applicable, limited nursing and medication services, including frequency of service and level of assistance.

The Individual Plan of Care shall be reviewed by the provider, the consumer or the consumer's representative, and the HCBS Medicaid Waiver case manager, and updated in at least every ninety (90) days; and more often as the consumer's condition changes or as determined by the case manager, provider or consumer.

A review note with the date and reviewer's signature shall be documented in the record at the time of the review. If the Individual Plan of Care contains many changes and becomes less legible, a new Individual plan of care shall be written.

The provider shall provide the consumer, HCBS Medicaid Waiver case manager, and AAA, with a copy of the Individual Plan of Care, and place a copy in the consumer file.

The provider will update the plan when there are changes in the services the consumer needs and wants to receive. At a minimum, the provider shall review and update the Individual plan of care every ninety (90) days.

The Plan of Care for the consumer must be cost neutral (as defined in the A&D Manual). The initial Level of Service Assessment will be performed by the AAA Waiver case manager with input from the applicant/guardian.

Plan of Care/Updates/Revisions: Periodic reviews will take place to determine the appropriateness and adequacy of the services with regard to the consumer's needs. The consumer's case manager along with other interested persons, as appropriate, will conduct an on-site face-to-face review of the Level of Services Assessment and the delivery of services under the Plan of Care at least every 90 days. This visit will occur in the home setting and will include a general consumer status review (See attached form B) that will be completed by the case manager, with input from consumer, guardian, and provider. The form will review indicators of health and safety, and any issues identified as problems will be immediately reported to the BQIS. A consumer may move from one level of service to another level (as determined by the Level of Service Assessment) with the same provider. When there is need to change the Level of Service or a provider, an updated Plan of Care/Cost comparison Budget will be submitted. It is the case manager's responsibility to assure the Plan of Care/Comparison Budget reflects the appropriate level of service that meets the needs of the consumer in an efficient and effective manner.

Annual Reassessments and Development of Annual Plan of Care/Cost Comparison Budget: Each consumer's Plan of Care/Cost Comparison budget will remain in effect for a period not to exceed 12 months. The Annual Plan of Care/Cost Comparison Budget will be cooperatively developed by the case manager, the consumer/guardian and provider during an on-site face-to-face visit. The Plan of Care/Cost Comparison Budget must be submitted via the current State approved electronic data base, to the State waiver unit for review at least 6 weeks prior to expiration of current plan but no earlier than 2 months prior to expiration of current plan. A new Level of Care Assessment must be completed as well as new Levels of Service Assessment.

All documentation by case manager must be entered in the current State approved electronic database.

The case manager must assure that each consumer is given the free choice of all qualified providers, including case managers. The consumer must sign the Freedom of Choice form. This must be documented in the State approved electronic database.

## **V. Quality Assessment and Provider Compliance**

### **A. Monitoring for Quality Assurance**

FSSA Waiver Services or designee shall conduct an inspection of the AFC home prior to issuance of a HCBS Medicaid Waiver Provider number, and will conduct an announced or unannounced inspection annually.

Inspection may also take place upon receipt of an oral or written complaint of violations that threaten the health, safety, or welfare of consumers; or anytime FSSA Waiver Services or designee has reason to believe a home has violated a condition or HCBS Medicaid Waiver standard, or is operating without a HCBS Medicaid Waiver Provider Agreement. Other situations requiring FSSA Waiver Services or designee inspection include anytime there is reason to believe a home has violated a condition or HCBS Medicaid Waiver standard, or is operating without a HCBS Medicaid Waiver Provider Agreement. Inspections may also take place for the purpose of routine monitoring of the consumer's care. Once an on site review has taken place, another inspection may be necessary to determine if cited deficiencies have been corrected. Mini inspections will also be completed during case manager visits, with completion of health and safety indicator checklist to identify any concerns.

State or local fire inspectors shall be permitted access to enter and inspect AFC homes regarding fire safety upon request of FSSA Waiver Services or designee.

FSSA Waiver Services or designee shall have full access and authority to examine and copy AFC home and consumer records. Copies may be requested and arrangements to make these copies will be the responsibility of the provider. The copying of these records must be done in a manner that is compliant with HIPAA Rules. FSSA Waiver Services or designee will also have access to inspect the physical premises, including the buildings, grounds, equipment and any vehicles relating to HCBS Medicaid Waiver Program participation and complaint investigations in the AFC home.

FSSA Waiver Services or designee has authority to interview the provider, primary caregiver, substitute caregivers, and consumers. Interviews shall be confidential and conducted privately.

Providers must authorize caregivers to permit entrance by the FSSA Waiver Services or designee for the purpose of inspection, investigation, and other duties within the scope of their authority.

FSSA Waiver Services or designee has authority to conduct inspections with or without advance notice to the provider, staff, or a consumer of the home. FSSA Waiver Services or designee shall not give advance notice of any inspection if

they believe that notice might obstruct or seriously diminish the effectiveness of the inspection or enforcement of these Certification Standards.

Inspectors will respect the private possessions of consumers and other consumers, providers and staff while conducting an inspection.

The ombudsman has the right to enter the home at the request of the consumer, providing any additional quality oversight.

## **B. Incident Reporting**

FSSA Waiver Services or designee shall furnish each AFC home with information on how a consumer can submit a complaint. This information must be kept in a conspicuous, readily accessible place and which states the telephone number at the state to which incidents must be reported. It will also list the ombudsman and the procedure for making complaints.

Incident Reporting within the waiver process: Based on the Aging Rule, any unusual occurrence will require an Incident Report to be completed by the provider and/or the case manager. Unusual occurrences include but are not limited to any of the following: abuse, neglect, un-explained injuries, death, etc.

The process for filing an Incident Report includes the following:

- 1) Incident is identified
- 2) Reporting entity reports the incident using the prescribed process (i.e.-web reporting system). The report includes a detailed explanation as to what happened, when, how it happened, action taken after the incident etc.
- 3) BQIS will review the incident, assign the appropriate coding (abuse, neglect, sentinel status etc)
- 4) BQIS will e-mail the incident report information to the case manager;
- 5) The case manager will follow up to ensure the health and safety is in place for the individual. The case manager will follow up every seven days until the incident is resolved.

FSSA Waiver Services, BQIS, or designee will work with the ombudsman and adult protective services to investigate and act on suspected abuse or exploitation immediately and to follow up on other complaints or concerns as quickly as possible. Incident Reports will be followed per the guidelines outlined above. The primary purpose of the prompt response is to protect the consumer and correct the situation. Investigations of complaints alleging injury, abuse or neglect shall be completed as soon as possible and in accordance with complaint standards utilized by the ombudsman program and adult protective services.

The AFC home provider shall not retaliate in any way against any consumer after the consumer or someone acting on his/her behalf has filed a complaint, been interviewed, or served as a witness, and must ensure that all caregivers follow the Incident Reporting procedures.

### C. Procedures for Corrections of Violations

If, as a result of an inspection or investigation, FSSA Waiver Services or designee determines that abuse has occurred, the provider shall be notified verbally to immediately cease the abusive act. The incident will be reported though the above guidelines and will be reported to adult protective services, arrangements will be made for immediate relocation of the consumer, and the provider's enrollment in the HCBS Medicaid Waiver Program will be terminated.

If an inspection or investigation indicates a violation of the Certification Standards other than abuse, FSSA Waiver Services or designee shall notify the provider in writing of violations of these Certification Standards.

FSSA Waiver Services may require the provider to develop a corrective action plan that will be approved by BQIS/FSSA DA.

The provider shall notify BQIS/FSSA DA of correction of violations no later than the date specified in the notice of violation.

FSSA Waiver Services or designee shall conduct a re-inspection of the home after the date that the FSSA Waiver Services receives the report of compliance or after the date by which violations must be corrected as specified in the notice of violation.

For violations that present an imminent danger to the health, safety or welfare of consumers, the HCBS Medicaid Waiver Provider Agreement may be immediately suspended and arrangements made to move the consumers.

If, after inspection of a home, the violations have not been corrected by the date specified in the notice of violation or if FSSA Waiver Services, BQIS, or designee has not received a report of compliance from provider, FSSA Waiver Services or designee shall terminate the HCBS Medicaid Waiver Provider Agreement.

### D. Disenrollment of Provider

FSSA Waiver Services or designee shall deny, suspend or revoke HCBS Medicaid Waiver Program Enrollment if a provider, caregiver or other person who has unsupervised access to consumers in the adult foster care home, has been:

1. Convicted of a crime against a person;
2. Convicted of a crime relating to financial exploitation;
3. Found by a court in a protection proceeding; to have abused or financially exploited a vulnerable adult;
4. Obtained or attempted to obtain HCBS Medicaid Waiver Program Enrollment by fraudulent means or misrepresentation;
5. Permitted, aided, or abetted the commission of any illegal act on the AFC home premises;



6. Been convicted of a felony or a crime against a person if the conviction reasonably relates to the competency of the person to own or operate an adult foster care home;
7. Been convicted of the illegal use of drugs or the excessive use of alcohol within the past five years without evidence of rehabilitation;
8. Been convicted of the illegal selling or distribution of drugs;
9. Been convicted of any crime involving a firearm used in the commission of a felony or in an act of violence against a person;
10. Refused to permit authorized FSSA DA representatives to interview consumers or have access to consumer records;
11. Interfered with an ombudsman, an adult protective services investigator, representatives of an FSSA DA recognized money management program, a HCBS Medicaid Waiver case manager, or any person or entity from an AAA or the FSSA DA in the performance of quality assurance and consumer protection activities on behalf of a citizen in the performance of official duties; and/or
12. Been found by the court in a proceeding to have committed an act of domestic violence toward a family or household member.

Failure of a provider to follow a consumer's Plan of Care, or any provisions of these Certification Standards, or failure by a provider to comply with the Consumer Rights established under any of the HCBS Medicaid Waiver Programs, is considered a willful violation of the HCBS Medicaid Waiver Programs and subject to disenrollment.

A provider whose HCBS Medicaid Waiver Provider Agreement has been revoked, voluntarily surrendered during a revocation/non-renewal process, or whose application has been denied shall not be permitted to re-enroll in the HCBS Medicaid Waiver Program for one year from the date the revocation, surrender, or denial is final, or for a longer period if specified in the order revoking or denying the enrollment.

FSSA Waiver Services shall deny, revoke, or refuse to renew the HCBS Medicaid Waiver Provider Agreement where it finds there has been substantial non-compliance with these standards or where there is substantial non-compliance with local codes and ordinances or any other State or Federal law or rule applicable to the health and safety of caring for consumers in an AFC home.

## **Indiana Adult Foster Care Provider Checklist**

### **I. Provider Eligibility and Enrollment**

- A. Legal entity
- B. Provider Application completed including
  - 1. Maximum consumer capacity
  - 2. Capacity of other occupants
  - 3. Service Level Classification requested
  - 4. Floor plan of house
  - 5. Three references (non-relatives of provider)
  - 6. Written operations plan including use of primary and substitute caregivers

### **II. Certification of AFC Provider Home**

- A. On-site provider files document all provider requirements are met
- B. Applicable local zoning, building and housing codes and state and local fire and safety regulations for a single family residence are met.
- C. Building and furnishings are clean and in good repair and grounds are well maintained.
- D. Home is inspected by the State Fire Marshal's Office with annual inspections by the local fire department kept on file.
- E. All consumers shall have unobstructed passageways throughout the house
- F. Universal precautions for infection control are followed in consumer care.
- G. Consumer's bathroom provides individual privacy and has a finished interior, with a mirror; a functioning window or other means of ventilation; and a window covering.
- H. All consumers have private or semi-private bedrooms; providers, caregivers, or their family members do not share bedrooms with consumers.
- I. Three regularly scheduled, nutritious meals are offered daily.
- J. A telephone is provided in the home and made available and accessible for consumers' use in a location that allows for a reasonable amount of privacy for incoming and outgoing calls.
- K. Hazardous Materials Requirements
- L. Fire Evacuation Requirements

### **III. Provider Maintained Files**

- A. Administrative Files On-site that include copies of all the documentation required for Provider Enrollment and Certification as well as substantiating documentation
- B. Consumer Personal File On-site personal files exist for each consumer including all prudent personal information about consumer
- C. Financial Records On-site are maintained
- D. Consumer Contract
- E. Primary and Substitute Caregiver Requirements
  - 1. Primary Caregiver resides in the home.
  - 2. Twenty-one (21) years of age or older.
  - 3. Completed the FSSA Waiver Services or designee approved training course.
  - 4. Documented passing of a criminal record check
  - 5. Literate and demonstrate an understanding of written and oral orders.
  - 6. Able to communicate with consumers.

- 7. Annual physical, including TB test with a statement from physician indicating date and that they are free from TB.
- F. Prior to admission of the first HCBS Medicaid Waiver consumer to the AFC home, and annually thereafter, the provider, primary, and any substitute caregivers have completed basic first aid, CPR, and fire safety.
- G. Care and Service Standards require any services performed under the HCBS Medicaid Waiver Programs for persons who are aged or medically disabled must comply with the prohibitions regarding the practice of medicine under IC 25-22.5-1.
- H. Provider must meet with potential consumer prior to admission.

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**Indiana Adult Foster Care Survey Tool**

**Indiana Family and Social Services Administration**  
**Division of Aging**  
**Approval Request**  
**For**  
**Agency Providers of Adult Foster Care**

The Indiana Family and Social Services Administration Medicaid Waiver Program is responsible for approval of providers for Adult Foster Care under Medicaid Home and Community Based Services administered by the Division of Aging.

The attached Service Definition, Provision and Certification Standards, and the Adult Foster Care Survey Tool are used in this process. To apply for approval, please complete the enclosed Survey Tool. Return the completed Tool and all documentation requested to:

Linda Wolcott, Waiver Operations  
MS21 Division of Aging  
402 W. Washington Street, Room W454  
P.O. Box 7083  
Indianapolis, IN 46207-7083

When your home is fully operational with private pay clients and is in compliance with all of the requirements in this survey, the Medicaid Waiver staff will then arrange a date and time for an on-site inspection of the Adult Foster Care home and provider records: administrative, personnel, and consumer.

Any approval granted by FSSA upon review of such application and inspection shall be for the purpose of enrollment in the specific service for which approval is sought and shall be subject to the provider's execution of a Provider Agreement with the Office of Medicaid Policy and Planning (for Medicaid Waiver programs) or a contract with the appropriate Area Agency on Aging (for other funding programs). The facility will abide by all terms and conditions of such Provider Agreement and/or contract.

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Provider Name

---

Address

City

Zip

---

Contact Person

Telephone

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Email address

**Definition of Adult Foster Care**

Adult Foster Care (AFC) is a comprehensive service provided under the Family and Social Services Administration's (FSSA) Waiver Services Aged and Disabled (A&D) Medicaid Waiver. The service differs slightly from the Adult Foster Care service provision within the Developmental Disabilities Waiver. All descriptions in this document refer to the service as provided in the A&D Waiver.

An AFC consumer resides with a caregiver, in a home owned by the Adult Foster Care (AFC) provider, in order to receive personal assistance in a home setting that is safe and secure.

The goal of the HCBS Medicaid Waiver service is to provide necessary care while emphasizing the consumer's independence. This goal is reached through a cooperative relationship between the consumer (or the consumer's legal guardian), the consumer's HCBS Medicaid Waiver case manager, and the care provider in a setting that protects and encourages consumer dignity, choice, and decision-making. Consumer needs shall be addressed in a manner that support and enable the individual to maximize abilities to function at the highest level of independence possible. The service is designed to provide options for alternative long-term care to persons who meet Nursing Facility level of care, and whose needs can be met in an AFC setting.

The AFC home shall consist of a ratio of one Primary Caregiver to a maximum of three (3) Consumers. The AFC Caregiver's family may also reside in the home, allowing the special one-to-one attention and care that the consumer may desire and deserve. The goal is to preserve the dignity and self-respect of by ensuring high quality, professional care in a non-institutional setting. Care is to be furnished in a way that fosters the independence of each consumer to facilitate aging in place in a home environment that will provide the consumer with a range of care options as the needs of the consumer change.

**Appendix B**  
**Indiana Adult Foster Care Survey Tool**

<b>Adult Foster Care Requirement</b>	<b>Met</b>	<b>Not Met</b>	<b>Planned Date of Compliance</b>	<b>Verified Compliance</b>
<b>I. Provider Eligibility and Enrollment</b>				
A. Legal Entity- Is the AFC provider a recognized legal entity authorized to do business in the State of Indiana?				
B. Provider enrollment application is complete including documentation of:				
1. The maximum consumer capacity requested (not to exceed 3). <b>S</b>				
2. The number of any other occupants. <b>S</b>				
3. The service level classification being requested. <b>S</b>				
4. A floor plan of the house showing location and size of rooms, exits, wheelchair ramps if applicable, smoke detectors and extinguishers. The floor plan shall show exits and directions for vacating the premises. <b>S</b>				
5. A list of three reliable references, at least three of whom must be non-relatives that have current knowledge of the provider-applicant's character and capabilities. <b>S</b>				
6. A written plan describing the planned operation of the AFC home, including the use of primary caregivers other than the provider, and substitute caregivers. <b>S</b>				
<b>II. Certification of AFC Provider Home</b>				
A. On-site provider files that document that all provider requirements are met (i.e.: liability insurance, current annual physical exam, etc.) are present, and available for review by inspector.				
B. All applicable local zoning, building and housing codes and state and local fire and safety regulations for a single family residence are met.				
C. The building and furnishings are clean and in good repair and grounds are well maintained.				
D. The home is inspected for fire safety by the State Fire Marshal's Office with annual inspections by the local fire department kept on file.				

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<b>Adult Foster Care Requirement</b>	<b>Met</b>	<b>Not Met</b>	<b>Planned Date of Compliance</b>	<b>Verified Compliance</b>
1. At least one working fire extinguisher is in a visible and readily accessible location on each floor, including basements, and shall be inspected at least once a year.				
2. Fire extinguishers shall be tagged, with a signature and date of inspection.				
D. All consumers shall have unobstructed passageways throughout the house.				
1. Interior and exterior stairways are provided with handrails.				
2. Adequate lighting, based on the needs of the individual is provided in each room, stairway, and exit-way. Incandescent light bulbs are protected with appropriate covers.				
3. Yard, approved exits and exterior steps are accessible and appropriate to the condition of the consumers.				
E. Heating and cooling systems are in working order.				
F. All exit doors and interior doors have simple hardware that cannot be locked against exit without an obvious method of operation, and which does not require a key when locked against exit.				
G. All common use areas of the house and exits are barrier free.				
1. Corridors and hallways are wide enough to accommodate a walker or wheelchair.				
2. Any bedroom window identified as an exit is free of any obstacles, at least the width of the window.				
3. A wheelchair ramp is present from a minimum of one exterior door if non-ambulatory persons are in residence. Wheelchair ramps shall meet the standards of the Americans with Disabilities Act.				
4. There is non-skid backing on throw/scatter rugs				
H. There are readily available basic first-aid supplies and a first-aid manual.				
I. A public water supply is utilized if available. If a non-municipal water source is used, minimum water quality standards must be met.				

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<b>Adult Foster Care Requirement</b>	<b>Met</b>	<b>Not Met</b>	<b>Planned Date of Compliance</b>	<b>Verified Compliance</b>
J. Septic tanks or other non-municipal sewage disposal system are in good working order.				
K. Garbage and refuse are suitably stored in clean, rodent-proof, covered containers, pending weekly removal.				
L. Soiled linens and clothing are stored in closed containers in an area separate from food storage, kitchen and dining areas.				
M. Sanitation for household pets and other domestic animals is adequate to prevent health hazards.				
1. Proof of rabies or other vaccinations required by a certified veterinarian are maintained on the premises for household pets.				
2. Pets not confined in enclosures are under control and do not present a danger to consumers or guests.				
N. There is adequate control of insects and rodents including screens on doors and windows that are used for ventilation.				
O. Universal precautions for infection control are followed in consumer care. Hands and other skin surfaces are washed immediately and thoroughly if contaminated with blood or other body fluids.				
P. Bathroom specifications:				
1. Consumer's bathroom provides individual privacy and has a finished interior, with a mirror; a functioning window or other means of ventilation; and a window covering.				
2. The room is clean and free of objectionable odors. There are tubs or showers, toilets and sinks in good repair.				
3. Bathrooms have hot and cold water at each tub, shower, and sink in sufficient supply to meet the needs of the consumers.				
4. Hot water temperature in bathing areas is supervised for persons unable to regulate water temperature.				
5. Shower curtains and doors are clean and in good condition.				
6. Non-slip floor surfaces shall be				



**Appendix B**  
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<b>Adult Foster Care Requirement</b>	<b>Met</b>	<b>Not Met</b>	<b>Planned Date of Compliance</b>	<b>Verified Compliance</b>
provided in tubs and showers.				
7. Safe and secure grab bars for toilets, tubs, and/or showers are installed for consumer's safety.				
8. Adequate supplies of toilet paper and soap are available.				
9. Consumers are provided with individual towels and washcloths, which are laundered in hot water at least weekly or more often if necessary.				
10. There are appropriate racks or hooks for drying bath linens.				
<b>Q. Bedroom specifications:</b>				
1. All consumers have private or semi-private bedrooms; providers, caregivers, or their family members do not share bedrooms with consumers.				
2. An individual bed that consists of a mattress and springs, or equivalent, in good condition is provided.				
3. Clean bedding in good condition consisting of a bedspread, mattress pad, two sheets, a pillow, a pillowcase, and blankets adequate for the weather are provided.				
4. Sheets and pillowcases are laundered at least weekly, and more often if soiled. Waterproof mattress covers are used for incontinent consumers.				
5. Sufficient space for each consumer's clothing and personal effects including hygiene and grooming supplies is provided				
6. Consumers are allowed to keep and use some of their personal belongings and have private, secure storage space. The amount of belongings allowed will be agreed upon by consumer and provider, with consideration to health and safety issues in the home. Personal property will be itemized and recorded for protection of the consumer, with copy maintained by consumer or legal guardian.				
7. Drapes or shades for windows are in good condition and allow privacy for consumers.				
8. Bedrooms are on ground level for				

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<b>Adult Foster Care Requirement</b>	<b>Met</b>	<b>Not Met</b>	<b>Planned Date of Compliance</b>	<b>Verified Compliance</b>
consumers who are non-ambulatory, have impaired mobility, or are cognitively impaired.				
9. Consumers on the second floor or in the basement can demonstrate their self-preservation capability to self-exit or barricade, i.e., close the door or stop smoke from coming under the door.				
10. At least one window or exterior door can be readily opened from the inside without special tools and provides a clear opening.				
11. There should be a designated common area for consumer to watch TV, socialize, receive visitors, etc.				
<b>R. Meal Specifications:</b>				
1. Three regularly scheduled, nutritious meals are offered daily.				
2. Nutritious snacks and liquids are available and offered to fulfill each consumer's nutritional requirements.				
3. Special consideration is given to consumers with chewing difficulties and other eating limitations.				
4. Special diets are followed as prescribed in writing by the consumer's physician/nurse practitioner.				
5. Food is stored and maintained at the correct temperature in a properly functioning refrigerator.				
6. Utensils, dishes and glassware are washed by dishwasher or by hand in hot soapy water, rinsed, and stored to prevent contamination.				
<b>S. Communication specifications:</b>				
1. A telephone is provided in the home and made available and accessible for consumers' use in a location that allows for a reasonable amount of privacy for incoming and outgoing calls.				
2. Consumers with hearing impairments (to the extent that they cannot hear over a normal phone) are provided with a telephone that is amplified with a volume control or is hearing aid compatible.				
3. The telephone number is a listed				

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<b>Adult Foster Care Requirement</b>	<b>Met</b>	<b>Not Met</b>	<b>Planned Date of Compliance</b>	<b>Verified Compliance</b>
number.				
4. Emergency telephone numbers are posted by the telephone including an emergency number to reach a provider who does not live in the home.				
5. Telephone numbers for the State Ombudsman and the local ombudsman are also posted.				
T. The provider has initiated a Consumer Risk Management Contract for each consumer.				
U. Smoke Detector Requirements:				
1. Detectors are installed in accordance with the manufacturer's listing in each bedroom, in hallways or access areas that adjoin bedrooms, family room or main living area where consumers congregate, any interior designated smoking area, in basements, and, in two-story houses, smoke detectors are installed at the top of the stairway to the second floor.				
2. Detectors are equipped with a device that warns of low battery when battery operated or with a battery backup if hard wired.				
3. Battery-operated smoke detectors are tested monthly and batteries changed at least once per year.				
4. Bedrooms used by hearing-impaired occupants who cannot hear a regular smoke alarm are equipped with a visual/audio or vibration alerting smoke alarm as appropriate.				
5. All smoke detectors contain a sounding device or are interconnected to other detectors to provide, when actuated, an alarm that is audible in all sleeping rooms.				
V. Hazardous Materials Requirements:				
1. Flammable and combustible liquids and hazardous materials are safely and properly stored in original, properly labeled containers or safety containers and secured in areas to prevent tampering by consumers or vandals.				
2. Cleaning supplies, medical sharps				

**Appendix B**  
**Indiana Adult Foster Care Survey Tool**

<b>Adult Foster Care Requirement</b>	<b>Met</b>	<b>Not Met</b>	<b>Planned Date of Compliance</b>	<b>Verified Compliance</b>
containers, poisons and insecticides are properly stored in original, properly labeled containers in a safe area away from food preparation and storage areas, dining areas, and medications.				
3. Firearms owned by the primary caregiver are stored, unloaded, in a locked cabinet. The firearms cabinet is located in an area of the home that is not accessible to consumers.				
4. If firearms are present, this fact is addressed in the Consumer Contract, for benefit of consumer awareness.				
5. Consumers are not allowed to bring firearms into the home.				
<b>W. Fire Evacuation Requirements:</b>				
1. An emergency evacuation plan has been developed, posted and rehearsed with occupants.				
2. All caregivers are required to demonstrate the ability to quickly evacuate all consumers from the home to the closest point of safety, which is exterior to, and away from the structure.				
3. Within 24 hours of arrival, any new consumer or caregiver is shown how to respond to a fire alarm, shown how to evacuate from the home in an emergency, and receives an orientation to basic fire safety.				
4. A floor plan containing room sizes, location of each consumer's bedroom, fire exits, caregiver's sleeping room, smoke detectors and fire extinguishers is posted.				
5. There is a second safe means of egress from each room.				
6. There is at least one plug-in rechargeable flashlight available on each floor for emergency lighting that is checked on a monthly basis.				
<b>7. Smoking policies</b>				
a. Smoking is prohibited in sleeping rooms, homes where oxygen is used, or in garages where flammable materials are stored.				
b. Smoking is allowed only in				

**Appendix B**  
**Indiana Adult Foster Care Survey Tool**

<b>Adult Foster Care Requirement</b>	<b>Met</b>	<b>Not Met</b>	<b>Planned Date of Compliance</b>	<b>Verified Compliance</b>
designated areas.				
c. Ashtrays of noncombustible material and safe design are provided in areas where smoking is permitted.				
<b>III. Provider Maintained Files</b>				
<b>A. Administrative Files</b> On-site provider files that include copies of all the documentation required for Provider Enrollment and Certification as well as substantiating documentation including, but not limited to the following:				
1. Provider Application and listed documentation of Section I-B and II-A and II-B				
2. Fire Inspection Report.				
3. Emergency Plans.				
4. Contact Numbers.				
5. Training Certifications of all caregivers.				
6. Insurance Documentation. <b>S</b>				
7. Liability Insurance of at least one hundred thousand dollars per occurrence <b>S</b>				
8. Required Health Records.				
9. Required Safety Records.				
10. Medicaid Provider Agreement.				
11. Agreements with FSSA Waiver Services.				
<b>B. Consumer Personal File</b> On-site personal files exist for each consumer including all prudent personal information about consumer, including, but not limited to the following:				
1. Name.				
2. Date of Birth.				
3. Social Security Number.				
4. Family Contact.				
5. Medical Information				
6. Current Plan of Care.				
7. Legal Documents if established				
a. Guardianship				
b. Power of Attorney				
c. Healthcare Representative				
d. Living Will Documents				
8. Incident Reports involving health and safety.				
9. Progress/ Status Note at least once				

**Appendix B**  
**Indiana Adult Foster Care Survey Tool**

<b>Adult Foster Care Requirement</b>	<b>Met</b>	<b>Not Met</b>	<b>Planned Date of Compliance</b>	<b>Verified Compliance</b>
every seven days.				
10. Provider is aware and understands all privacy and HIPAA regulations concerning consumer's records and information.				
C. Financial Records On-site financial records are maintained including, but not limited to :				
1. Agreements between provider and consumer, relatives, or person paying for care.				
2. If the provider manages or handles a consumer's money, a separate account record is maintained in the consumer's name.				
a. Amounts and sources of funds received and issued are clearly shown.				
b. Purchases of \$5.00 or more, made on behalf of a consumer, are documented by receipts.				
3. Financial planning sheets prescribed by FSSA Waiver Services, or designee.				
D. Consumer Contract Prior to admission, the AFC services provider completes a Consumer Contract with each potential consumer or his/her designated representative.				
1. The contract covers the following topics:				
a. Name of consumer.				
b. Name of consumer's designated representative, if applicable.				
c. Street & Mailing Address of AFC home.				
d. Term of contract- reviewed annually.				
e. Description of services provided in Waiver program.				
f. Description of additional services provided outside of the Waiver program.				
g. Process through which contract may be modified, amended, or terminated.				
h. Complaint resolution procedures.				
i. House Rules.				
j.. Consumer Rights.				
2. The consumer and/or designated				

**Appendix B**  
**Indiana Adult Foster Care Survey Tool**

<b>Adult Foster Care Requirement</b>	<b>Met</b>	<b>Not Met</b>	<b>Planned Date of Compliance</b>	<b>Verified Compliance</b>
representative, if applicable, are provided copies of the signed contract				
<b>E. Information Accessibility</b> The provider has readily-available and freely- accessible to the consumer and others the following information:				
1. Ombudsman Poster including address and telephone number of the Local and State Ombudsman program.				
2. Address and Telephone number of the local Area Agency on Aging.				
3. DDARS Provider Agreement and any attached conditions, if applicable.				
4. Consumer Rights.				
5. House Rules.				
6. Floor Plan indicating the fire evacuation route. <b>S</b>				
7. FSSA Waiver Services or designee inspection form. <b>S</b>				
8. DDARS or designee procedures for making complaints.				
<b>F. Primary and Substitute Caregiver Requirements</b>				
1. Primary Caregiver resides in the home.				
2. Twenty-one (21) years of age or older. <b>S</b>				
3. Completed the FSSA Waiver Services or designee approved training course.				
4. Documented passing of a criminal record check				
5. Literate and demonstrate an understanding of written and oral orders. <b>S</b>				
6. Able to communicate with consumers.				
7. Annual physical, including TB test with a statement from physician indicating date and that they are free from TB.				
<b>G. Training Requirements of Caregivers</b> Prior to admission of the first HCBS Medicaid Waiver consumer to the AFC home, and annually thereafter, the provider, primary, and any substitute caregivers have completed:				
1. Basic First Aid course- may be				

**Appendix B**  
**Indiana Adult Foster Care Survey Tool**

<b>Adult Foster Care Requirement</b>	<b>Met</b>	<b>Not Met</b>	<b>Planned Date of Compliance</b>	<b>Verified Compliance</b>
waived for a substitute caregiver who holds a current Indiana license as a healthcare professional (i.e. physician, RN, LPN). <b>S</b>				
2. CPR course. <b>S</b>				
3. Fire safety training				
H. Care and Service Standards Any services performed under the HCBS Medicaid Waiver Programs for persons who are aged or medically disabled must comply with the prohibitions regarding the practice of medicine under IC 25-22.5-1.				
1. A calendar exists and is readily accessible for the consumer and caregiver that include scheduled activities, all medical appointments and other services, and medication chart, if indicated.				
2. The Adult Foster Care Service includes the provision of personal care and services, homemaker, chore, attendant care and companion services, and medication oversight, to the extent permitted under State law.				
3. The caregiver provides, arranges, or makes available 3 meals/day, 7 days/week that provide a balanced distribution of the daily nutritional requirements.				
4. Medications, Treatments and Therapies: The provider and caregivers demonstrate an understanding of each consumer's medication administration regimen, including the reason for the medication is used, medication actions, specific instructions and common side effects.				
a. Written, signed orders are in the consumer's record for any medications prescribed by the physician/ nurse practitioner.				
b. Order changes obtained by telephone are documented by filing the pharmacy receipt detailing specifics regarding the prescription.				
c. Over-the-counter medication requested by the consumer is addressed in				



**Appendix B**  
**Indiana Adult Foster Care Survey Tool**

<b>Adult Foster Care Requirement</b>	<b>Met</b>	<b>Not Met</b>	<b>Planned Date of Compliance</b>	<b>Verified Compliance</b>
the plan of care, and is reviewed by the consumer's physician, nurse practitioner, or pharmacist as part of developing the care plan and at time of care plan review.				
d. "as needed" or "p.r.n." medications have written directions by a physician, nurse practitioner, registered nurse, or pharmacist which show what the medication is for and specifically when, how much and how often it may be administered.				
e. Self-Medication Consumers have a physician/nurse practitioner's written order of approval to self-medicate.				
i. Medications are kept in the consumer's room in a small storage area that can be locked.				
ii. Each medication container is clearly labeled with the pharmacist's label or is in the original labeled container or bubble pack.				
iii. Both caregiver and consumer have ready access to consumer's medications.				
iv. Consumers do not have access to medications of the provider or other household members, nor do individuals other than the primary caregiver have access to each consumer's locked medication.				
f. Provider Assisted Medication For some consumers, it will be necessary that the provider oversees the consumer's medicine intake as follows:				
i. A current, written medication administration record is kept for each consumer and identifies all of the medications administered by the caregiver to the consumer, including over-the-counter medications and prescribed dietary supplements.				
ii. Discontinued or changed medication orders are marked and dated on the medication administration record as discontinued.				

**Appendix B**  
**Indiana Adult Foster Care Survey Tool**

<b>Adult Foster Care Requirement</b>	<b>Met</b>	<b>Not Met</b>	<b>Planned Date of Compliance</b>	<b>Verified Compliance</b>
iii. Missed or refused medication, treatment or therapy is documented the initials must be circled and a brief but complete explanation must be recorded on the back of the medication record.				
5. A caregiver is present and available at the home at all times when consumers are in the home.				
6. Activities are available each week that are of interest to the consumers.				
7. Providers or caregivers are directly involved with consumers on a daily basis.				
<b>I. Admission Requirements</b> Prior to placement, the Provider, with the assistance of the case manager, meets with potential consumers who are interested in residing in this AFC home.				
1. The provider obtains and documents general information regarding the consumer including:				
a. Names, addresses, and telephone numbers of relatives, significant persons, case managers, and medical/mental health providers.				
b. Date of admission				
c. Consumer's Social Security and medical insurance numbers				
d. Birth date				
e. Prior residence				
f. Hospital preference				
g. Mortuary preference				
h. Medical information available including history of accidents, illnesses, impairments or mental status that may be pertinent to the consumer's care.				
i. Documentation obtained in compliance with Section III-B.				
2. After admission of a consumer, the provider continues the assessment process, including documenting the consumer's preferences and observed care needs. This information is presented to the case manager at the 90-day review.				

**Appendix B**  
**Indiana Adult Foster Care Survey Tool**

Site visit comments:

Assessor Name

Date

Assessor Name

Date

Assessor Name

Date

**Appendix B**  
**Indiana Adult Foster Care Survey Tool**

## **AFC Consumer Personal File**

**Name** \_\_\_\_\_

**Start Date of Services in AFC Home** \_\_\_\_\_

**The following information is contained in this personal file for the above AFC consumer.**

- I. Personal Identification Information and Contact Names**
- II. Medical Information**
- III. Current HCBS Plan of Care**
- IV. Legal Documents if established.**
  - a. Guardianship**
  - b. Power of Attorney**
  - c. Healthcare representative**
  - d. Living Will Documents**
- V. Copies of all Incident Reports involving Health and Safety**
- VI. Progress Notes entered at least weekly**

## I. Personal Identification

### Consumer Information

Name\_\_\_\_\_

Date entered AFC Home

\_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number\_\_\_\_\_

### Contact Information

Primary Family Contact:

Relationship to AFC Consumer :

Contact Phone Number(s):

Address :

Secondary Contact :

Relationship to AFC Consumer:

Contact Phone Number(s):

Address:

## **II. Medical Information**

**The following medical information is confidential.**

AFC Consumer Name:

Primary Diagnosis:

Secondary Diagnosis:

Personal Physician:

Phone:

Address:



### **III. Current HCBS Plan of Care**

(See attached)

#### **IV. Legal Documents (if established)**

See attached. Indicate if the form is not established. If form exists, must be in file.

- a. Guardianship**
- b. Power of Attorney**
- c. Healthcare representative**
- d. Living Will Documents**

## **V. Copies of all Incident Reports involving Health and Safety**

See attached. All Incident Reports must be signed and dated by reporting AFC provider.

## **VI. Progress Notes**

See attached. Notes are to be entered on a weekly basis. Reporting AFC  
Provider is to sign and date each entry.

**AFC House Rules**

The following agreed upon general rules will be considered to be House Rules and will be followed by all persons residing in this Adult Foster Care Home.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

\_\_\_\_\_  
**AFC Provider Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**AFC Consumer Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Legal Guardian Signature, if indicated**

\_\_\_\_\_  
**Date**

## Appendix C

### Provider Sample Forms

## Medication Administration Record

**Name** \_\_\_\_\_

## Prescription History

[illegible]

## Appendix C

### Provider Sample Forms

### Medication Usage Chart

[illegible]

**Case Manager Checklist for On-Site Visits to AFC Home**

**Consumer Name** \_\_\_\_\_

**Provider Name and Address** \_\_\_\_\_

\_\_\_\_\_

**Date of Visit** \_\_\_\_\_ **Case Manager** \_\_\_\_\_

\_\_\_\_\_ 1. Consumer and Primary Caregiver appear to be at ease with each other, and consumer reports a comfortable, positive relationship with all caregivers as well as other residents in the home. Consumer is content with the AFC home environment, and appears to be experiencing good quality of life. There are no more than three consumers residing in the AFC home.

**Notes/Observations/Follow Up:**

\_\_\_\_\_ 2. Consumer appears clean, with clean clothing in satisfactory repair. Consumer appears to be well nourished and reports that any special dietary needs are addressed and meals are satisfactory. Bedroom and linens are clean and comfortable, and consumer appears well rested.

**Notes/Observations/Follow Up:**

\_\_\_\_\_ 3. Consumer's overall condition, mentally and physically, would indicate that the current Level of Service Need on record is appropriate and is in line with the provisions of the AFC Home in which she/he resides.

**Notes/Observations/Follow Up:**

\_\_\_\_\_ 4. Consumer has access to telephone use, and emergency numbers are well posted or easily accessed independently. The local and State Ombudsman phone numbers must be posted, and consumer should know how to contact these numbers.

**Notes/Observations/Follow Up:**

\_\_\_\_\_ 5. Consumer can report that he/she has control over his/her own time, and attends all medical and other appointments as needed or designated by Plan of Care. Transportation is provided or arranged in order for consumer to maintain natural support system and to participate in community and social activities as desired or as specified in Plan of Care or Consumer Contract.

**Notes/Observations/Follow Up:**



## Appendix C

### Provider Sample Forms

\_\_\_\_\_ 6. Home is in good repair and appears to be a clean, sanitary, comfortable homelike environment. Living areas, including all hallways, are barrier free and consumer is able to get around throughout the house. Stairways are clear and have safe handrails. Exits are not blocked, or locked without ability to exit safely in an emergency.

**Notes/Observations/Follow Up:**

\_\_\_\_\_ 7. Utilities are in good working order, including gas and electric, with reasonable room temperature, water supply, and lighting. Living space is properly ventilated. Major appliances and plumbing are all in good working order.

**Notes/Observations/Follow Up:**

\_\_\_\_\_ 8. Shower or bathtub is clean, and in good repair with non-slip floor surface. Grab bars are present for bathtub, shower, and toilet. Linens are clean, and room provides privacy.

**Notes/Observations/Follow Up:**

\_\_\_\_\_ 9. Smoke detectors are present and in working order, as specified by rule (located in each bedroom, at top of stairways in two-story home, in hallways or areas that adjoin bedrooms, family rooms, or main living area, and in any designated smoking area and basement. Fire extinguishers are readily available to consumer. Consumer should be able to describe manner and route in which he/she would evacuate home in case of a fire.

**Notes/Observations/Follow Up:**

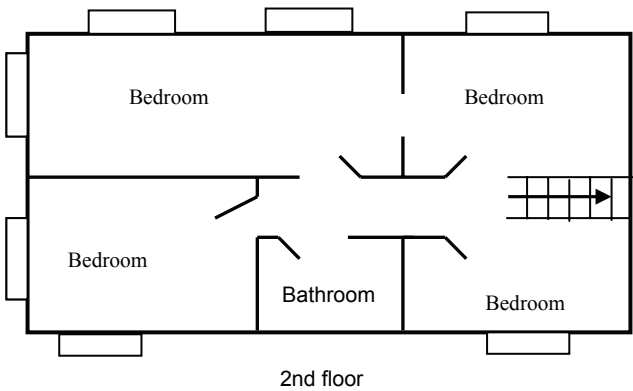
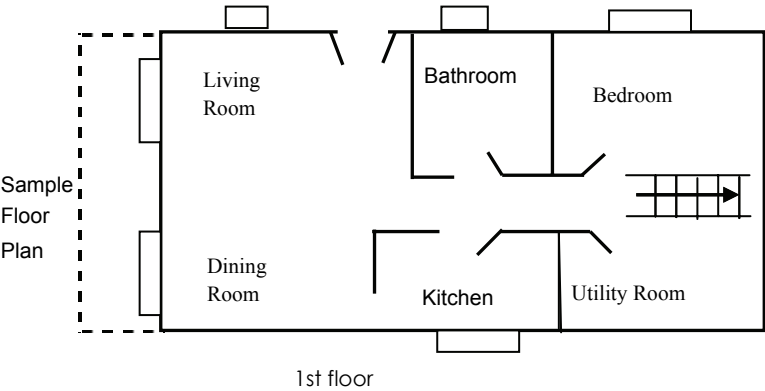
\_\_\_\_\_ 10. Provider is well informed about consumer's Plan of Care and service requirements, as well as any special needs that the consumer requires. Provider should have readily available the consumer's file, and should have current and complete documentation for Plan of Care, Consumer Contract, Consumer financial account record when provider assists with consumer's finances, and medication record with consumers who require assistance with tracking of medical regimen.

**Notes/Observations/Follow Up:**

Name of Provider \_\_\_\_\_

Date \_\_\_\_\_

# Floor Plan

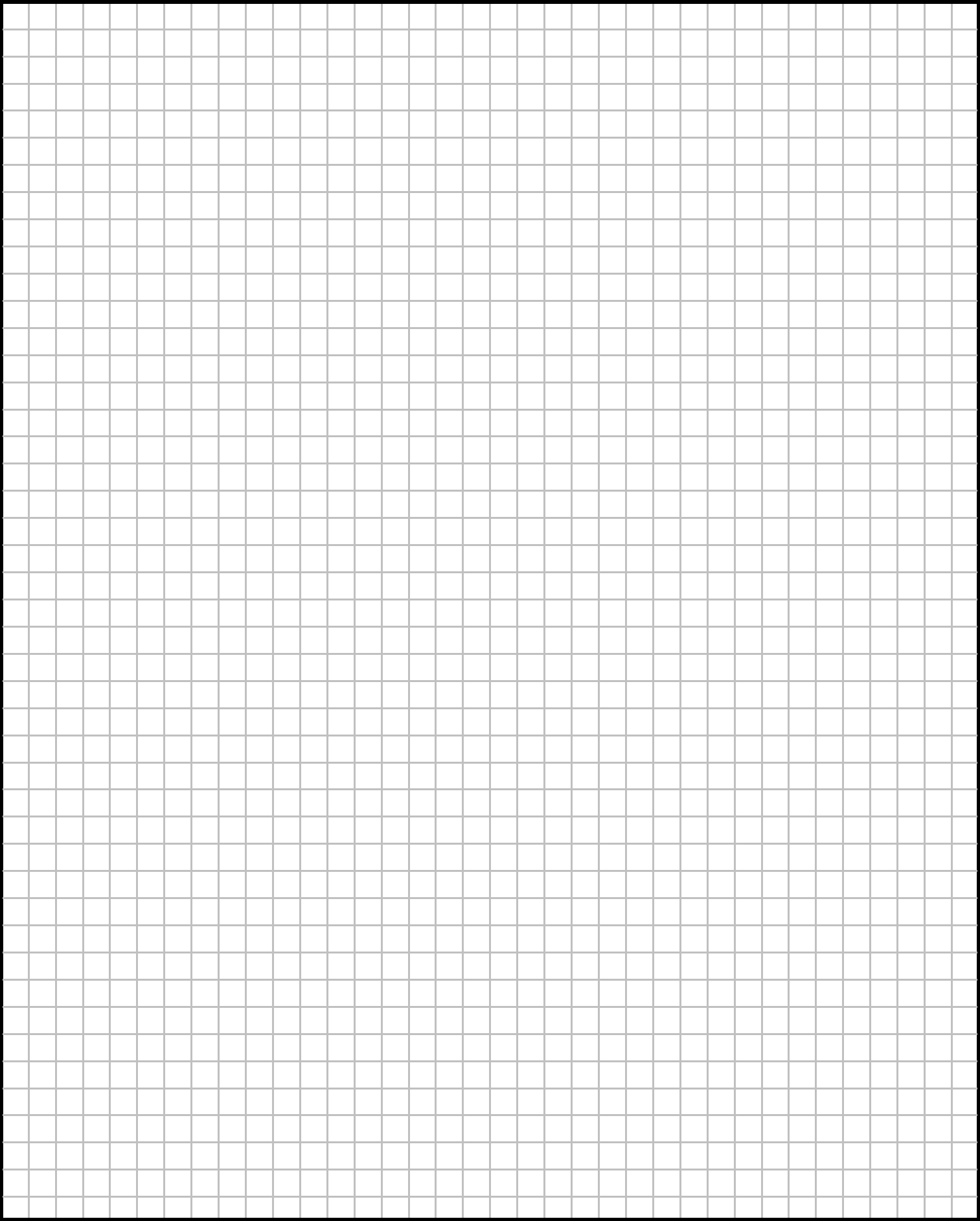


Use this grid to draw a floor plan  
Show the whole house and include doors and windows

Symbols to be used:

	window		stairs
	door		
	patio		

A large blue grid for drawing a floor plan, consisting of 30 columns and 20 rows of squares.





*"People  
helping people  
help  
themselves"*

Mitchell E. Daniels, Jr., Governor  
State of Indiana

***Division of Aging***  
402 W. WASHINGTON STREET, P.O. BOX 7083  
INDIANAPOLIS, IN 46207-7083

E. Mitchell Roob, Jr. Secretary

## FSSA DIVISION OF AGING

Policy Statement: 06-001 Revision  
Date of Notice Issued: 04-21-2006

Issued to: Nursing Facility Level of Care (NF LOC) Medicaid Waiver Providers of Home and Community Based Services (HCBS)  
Area Agencies on Aging (AAA)  
Case Managers

Authored by: Stephen A. Smith, Director, FSSA Division of Aging

Policy Topic: Requirement of NF LOC Medicaid Waiver Providers to be CHOICE Providers

Impacts the following Waivers: All NF LOC Medicaid Waivers

Effective Date: 07-01-2006

### Description of Policy Change, Update or Clarification:

On 12/06/2004, all HCBS Providers were given notification that in order for the provider to provide and be paid for HCBS through CHOICE, they would also be required to enroll as a Medicaid Waiver Provider. The deadline for that action was 01/01/2005.

As of 07/01/2006, the rates for both CHOICE services and NF LOC Medicaid Waiver services will undergo significant changes. In order to ensure that consumers of both programs will be served, providers of HCBS must be accessible to both groups of recipients.

NF LOC Medicaid Waiver Providers who are not currently enrolled as CHOICE HCBS Providers are now required to do so. To do this, NF LOC Medicaid Waiver Providers must contact the local AAA's that cover the counties in which they provide services under the Waiver, and make application to become a CHOICE Provider in those same counties only for those same services, that they provide through the Medicaid Waiver. This action should be completed by 05/15/2006 in order that they may be available as providers to those on CHOICE by 07/01/2006. The following exceptions will apply, in that CHOICE Providers will not be providing the following community residential and case management services:

- Assisted Living
- Adult Foster Care
- Case Management



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E. Mitchell Roob, Jr. Secretary

## NURSING FACILITY LEVEL OF CARE WAIVER PROVIDER INFORMATION WEBSITES

Aging Rule, 460 IAC 1.2 (effective 10/1/2006)

[http://www.in.gov/legislative/iac/iac\\_title?iact=460](http://www.in.gov/legislative/iac/iac_title?iact=460) (underscore between the second "iac" and the word "title")

Indiana OPTIONS (Division of Aging website)

[www.ltcoptions.in.gov](http://www.ltcoptions.in.gov)

EDS Website:

[www.indianamedicaid.com](http://www.indianamedicaid.com)

Waiver Provider Manual:

[www.indianamedicaid.com/ihcp/publications/manuals.html](http://www.indianamedicaid.com/ihcp/publications/manuals.html) (will be added to the Publications tab at the EDS website in the near future. A printed copy can be ordered from [BDDSHelp@fssa.in.gov](mailto:BDDSHelp@fssa.in.gov)

Consumer Guide to Indiana Medicaid Waiver Home and Community Based Services Waiver Programs:

<http://www.in.gov/gpcpd/publications#4>

Questions or further information? Call the Division of Aging 317-232-7122



**MEDICAID WAIVER PROVIDER**  
**Application for Certification**  
**For Home and Community Based Service (HCBS) Provision**  
**through the following Nursing Facility Level of Care Waiver(s)**

**Part 1. Demographic Information**

Check all that apply

☐ Aged and Disabled (A&D)

☐ Traumatic Brain Injury (TBI)

---

\_\_\_\_\_ Check one: ☐ New Application    ☐ Additional Services  
Date of Application

\_\_\_\_\_  
Legal Name (of person or agency)

\_\_\_\_\_  
DBA (Doing Business As) if applicable

\_\_\_\_\_  
Street Address (If additional service locations, please supply all information on this page for each location.)

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

(\_\_\_\_) \_\_\_\_\_  
Phone

(\_\_\_\_) \_\_\_\_\_  
Fax

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
CEO/Administrator

\_\_\_\_\_  
Contact Person

\_\_\_\_\_  
Title

**Type of Provider Entity (Check only one):**

☐ Individual

\_\_\_\_\_  
Social Security Number (SSN)

\_\_\_\_\_  
Medicaid Number

☐ Agency/Corporation

\_\_\_\_\_  
Federal ID Number

**If Agency, specify type:**

☐ Adult Day Services

☐ Adult Foster Care Home

☐ Assisted Living Facility

☐ Division of Disability and Rehabilitative Services (DDRS) Approved Agency

☐ Contractor/Construction

☐ Home/Community Service Agency (unlicensed)

☐ Home Health Agency (licensed)

☐ Retail Vendor

☐ Other (specify): \_\_\_\_\_

**Part 2. MINIMUM QUALIFICATIONS FOR SERVICE PROVIDERS**

All service providers (agency or individual) for the Nursing Facility Level of Care Medicaid waivers must be certified by the FSSA or its designee. This certification includes but is not limited to the completion and approval of the Waiver Application. All providers must abide by all of the provisions listed in their state licenses (if applicable), the Medicaid Waiver Provider Agreement and all other specified provisions as required by FSSA. A provider must have a valid signed Notice of Action (NOA) that specifies the service, the amount of units, and the effective date of the services, prior to providing services. The provider cannot at any time require the client to sign an agreement to pay any additional amount of money for services that they have agreed to provide under the waiver.

**General Agency Requirements**

- a. Must comply with any applicable federal, state, county, municipal regulations that govern the operations of the agency; and all FSSA laws, rules, policies; and any applicable licensure or certification requirements
- b. Must prove that appropriate and comprehensive insurance is in force
- c. Must provide proof that any individual employed by the agency meets all standards and requirements for the specific services of a waiver that the individual will be providing
- d. Must provide required training for any individual providing services for the waiver
- e. Must provide copies of all applicable licenses
- f. All agencies not licensed by the Indiana State Department of Health must obtain and submit a report (that is within the last 90 days) from the Nurse Aide Registry of the Indiana State Department of Health verifying that each employee or agent involved in the direct provision of services has not had a finding entered into the registry
- g. Must show proof that all RNs and LPNs on staff have had records checked through the Indiana Health Professions Bureau
- h. All agencies not licensed by the Indiana State Department of Health must obtain and submit a limited criminal history (that is within the last 90 days) from each employee involved in the direct management, administration, or provision of services from: The Indiana State Police Central Repository at 100 N. Senate Ave., Room N302, Indianapolis, IN 46204, 317-233-5424; and the county or counties of residence in the last 3 years

**General Individual Requirements**

- a. Must be at least 18 years of age
- b. Must demonstrate an ability to read and write adequately to complete required activities and meet service requirements
- c. Must demonstrate the ability to understand, read and write adequately to provide the services according to the plan of care for the client
- d. Must possess interpersonal skills necessary to work productively and cooperatively with clients of the waiver services and other service providers
- e. Must be in adequate physical health and free from physical limitations which would interfere with the ability to perform the tasks required
- f. Must be willing and able to accept on-going training as required or necessary
- g. Must submit proof that appropriate liability insurance is in force
- h. Must submit verification of freedom from communicable diseases as verified by physician by having a negative TB test or negative chest x-ray that has been completed within the last year
- i. Must submit verification of all licenses, certifications, trainings, experiences, or degrees required by a specific service or waiver
- j. Must show proof, if an RN or LPN, that record has been checked through the Indiana Health Professions Bureau
- k. Must obtain and submit a report (that is within the last 90 days) from the Nurse Aide Registry of the Indiana State Department of Health verifying that there is not a finding entered into the registry if involved in the direct provision of services
- l. Must obtain and submit a limited criminal history (that is within the last 90 days) from: The Indiana State Police Central Repository at 100 N. Senate Ave., Room N302, Indianapolis, IN 46204, 317-233-5424; and the county or counties of residence in the last 3 years if involved in the direct management, administration, or provision of services

**Part 3. Specific Certification Requirements**

**For Home/Community Service Agencies that provide any or all of the following services:**

Attendant Care, Homemaker, Respite Attendant Care, Respite Homemaker Services, Transportation

In addition to the completion of the Provider Application, the agency must comply with the following:

**Agency Assurances**

- Must be a recognized legal entity authorized to do business in the State of Indiana
- Must submit proof of Articles of Incorporation, Certificate of Incorporation, Organization, or Articles of Authority from the Secretary of State of Indiana
- Must submit proof of comprehensive insurance coverage
- Comply with all relevant federal, state, local, or municipal laws and regulations that govern the operation of the legal entity and the program
- Have a written drug free workplace policy
- Have a staff training plan
- Have back up staffing plan in place to ensure client coverage, and procedures in place to notify clients of any schedule changes
- Perform Client Satisfaction/Evaluation surveys annually
- Must submit list of all employees' names and job titles

**Personnel Requirements**

- Limited criminal history check from the Indiana State Police Central Repository at 100 N. Senate Ave., Room N302, Indianapolis, IN 46204, 317-233-5424; and the county or counties of residence of last 3 years for any individual providing direct management, administration, or provision of services
- Report (within the last 90 days) from the State Nurse Aide Registry of the Indiana State Department of Health verifying no findings are entered into the registry for each employee or agent involved in the direct provision of services
- Free from communicable diseases as verified by physician by having a negative TB test or negative chest x-ray that has been completed within the last year
- Current CPR certification (for employees providing attendant care /or respite attendant care services)
- Verification of Basic First Aid training (for employees providing attendant care and/or any respite services)
- Verification of training and/or experience as an attendant and/or homemaker



## Part 4. WAIVER SERVICES/CERTIFICATION REQUIREMENTS

Under each applicable waiver, check all services for which you are applying for certification at this time.  
Please note that not all services are available on all waivers or for all types of providers.

<u>Service Category</u>	<u>A&amp;D</u> Aged and Disabled	<u>TBI</u> Traumatic Brain Injury	<u>Certification Requirements</u> (in addition to the general requirements previously listed)
Adult Day Service (company) (A&D, TBI)	Level 1 ____ Level 2 ____ Level 3 ____	Level 1 ____ Level 2 ____ Level 3 ____	ADS Standards and Guidelines, application and site survey*
Adult Foster Care (individual) (A&D)	Level 1 ____ Level 2 ____ Level 3 ____ Level 4 ____ Level 5 ____		AFC Standards and Guidelines, application and site survey*
Assisted Living (facility) (A&D, AL)	Level 1 ____ Level 2 ____ Level 3 ____		AL Rule, Assessment Tool*; Residential Care License from ISDH; Housing with Services Disclosure form*
Attendant Care (individual, agencies) (A&D, TBI, MFC)			Individual: resume; current CPR; Home Community Services Agency guidelines; Community DD agency subject to BDDS approval.
Behavior Management (individual, agencies) (TBI)		Level 1 ____ Level 2 ____	Level 1: Psychologist and Health Services Provider in Psychology (HSPP) endorsement; Level 2: copy of Master's degree, copy of license (if applicable) and resume; Community DD agency subject to BDDS approval
Case Management (individual, agencies) (A&D, MFC, AL, TBI)			Individual certification is through their local Area Agency on Aging (AAA)
Congregate Care (A&D)	Level 1 ____ Level 2 ____ Level 3 ____		
Environmental Modifications (individual, agencies) (A&D, TBI, MFC)			Statement of Assurances and Compliance to ADA guidelines*; Individual: proof of insurance
Health Care Coordination (licensed home health agencies) (TBI)			copies of LPN and RN licenses; verification of Medicaid certification.
Home Delivered Meals (agencies) (A&D)			separate application*
Homemaker (individual, agencies) (A&D, TBI)			Home Community Services Agency guidelines; Community DD agency subject to BDDS approval; Individual: requires resume.
Personal Emergency Response Systems (individual, agencies) (A&D, TBI)			verification of qualified contractor (business or individual) and/or retail license
Physical Therapy (individual, agencies) (TBI)			
Occupational Therapy (individual, agencies) (TBI)			
Residential Habilitation (agencies) (TBI)			subject to BDDS approval

<u>Service Category</u>	<u>A&amp;D</u> Aged and Disabled	<u>TBI</u> Traumatic Brain Injury	<u>Certification Requirements</u> (in addition to the general requirements previously listed)
Respite Attendant Care (individual, agencies) (A&D, TBI)			Home Community Services Agency guidelines; Community DD agency subject to BDDS approval; Individual: requires resume; first aid training; CPR
Respite Home Health Aide (licensed home health agencies) (A&D, TBI)			
Respite Homemaker (individual, agencies) (A&D, TBI)			Home Community Services Agency guideline; Community DD agency subject to BDDS approval; Individual: requires resume; first aid training
Respite LPN (licensed home health agencies) (A&D, TBI, MFC)			
Respite RN (licensed home health agencies) (A&D, TBI, MFC)			
Specialized Medical Equipment and Supplies (individual, agencies) (A&D, TBI)			verification of qualified contractor (business or individual) and/or retail license; verification as required by the Registry for Interpreters of the Deaf (TBI)
Speech/Language Hearing Therapy (individual, agencies) (TBI)			
Structured Day Program (agencies) (TBI)			subject to BDDS approval; verification of CARF certification.
Supported Employment (agencies) (TBI)			subject to BDDS approval; verification of CARF certification
Transportation (agencies) (A&D, TBI)			Community DD agency subject to BDDS approval; verification of Medicaid certification; Statement of Assurances and Compliance for Transportation*
Vehicle Modification (individual, agencies) (A&D, TBI, MFC)			verification of qualified automotive vehicle specialist.

\*For additional applications and resources specified in this application,  
contact 317-232-7122.

**Part 5. Medicaid Waiver Provider's Statement of Assurances and Compliance**

Check off the assurances before signing. Signatures must be from an individual authorized to sign for the provider entity.

- ☐ 1. Provider assures that, if approved, the provider entity complies and will maintain compliance with all requirements as specified in this application, and all applicable state and federal statutes, regulations and licensure requirements for the approved service(s).
- ☐ 2. Provider assures that, if approved, the provider entity will provide only those Medicaid Home and Community Based Service(s) which have been authorized in the recipient's individual Plan of Care/Cost Comparison Budget, and in accordance with the Provider Agreement. and Certification requirements.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Submit the entire completed application, including the signed Statement of Assurances and Compliance, and all documentation for specified certification requirements.

**Incomplete applications will be returned.**

Mail application and all supporting documents to:

**Linda Wolcott, Waiver Operations  
MS 21 Division of Aging  
402 West Washington Street, Room W454  
P.O. Box 7083  
Indianapolis, In 46207-7083  
Phone (317) 234-0373  
Fax (317) 232-7867**

**SCHEDULE A**  
**INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION**  
**MEDICAID HOME AND COMMUNITY-BASED SERVICES**  
**WAIVER PROVIDER AGREEMENT**

Provider agrees to provide only those Medicaid Home and Community-Based Services which meet the following criteria:

1. Services which the Provider is licensed or certified to provide (if applicable);
2. Services for which the Provider has received formal certification form the Medicaid Waiver certification;
3. Services which have been authorized by the recipient's waiver case manager or targeted case manager (as appropriate) as set out in the recipient's Plan of Care; and
4. If applicable, in accordance with any addendum to this Agreement

Provider Name: \_\_\_\_\_

Doing Business As (if legal name is different from provider name stated above). If DBA name is different from provider name, provide documentation:

\_\_\_\_\_

Home Office address: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Pay To address: \_\_\_\_\_

Service Location(s) (if different from above): \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Social Security # or Federal ID# (not both): \_\_\_\_\_

Check one of the following: \_\_\_\_\_ Individual \_\_\_\_\_ Partnership  
\_\_\_\_\_ Corporation \_\_\_\_\_ Not-For-Profit

List current Medicaid Provider Number, if any: \_\_\_\_\_

List current Medicaid Waiver Provider number, if known: \_\_\_\_\_

List current Medicare Provider Number, if any, **and specify type (i.e., home health agency, AAA, etc.):**

\_\_\_\_\_

Typed or Printed Name of Authorized Representative: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

**INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION  
MEDICAID HOME AND COMMUNITY BASED SERVICES  
WAIVER PROVIDER AGREEMENT**

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider of services or supplies to recipients of Home and Community-Based Services authorized under the Medicaid Home and Community-Based Services Waiver Programs (hereinafter, "Medicaid Waiver"), and as a condition of enrollment, Provider agrees:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration (IFSSA).
2. To comply with all federal and state statutes and regulations pertaining to the Medicaid Program including the Medicaid Waiver Program, as they may be amended from time to time.
3. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the State of Indiana Medical Assistance law, State of Indiana's Medicaid Waiver program, or any rule or regulation promulgated pursuant thereto.
4. To notify IFSSA or its agent within then (10) days of any change in the status of Provider's license, certification or permit to provide its services to the public in the State of Indiana.
5. To provide Medicaid Waiver-covered services and/or supplies for which federal financial participation is available for Medicaid Waiver recipients pursuant to all applicable federal and state statutes and regulations.
6. To safeguard information about Medicaid recipients, including at least:
  - a. recipient's name, address, and social and economic circumstances;
  - b. medical services provided to recipients;
  - c. recipient's medical data, including diagnosis and past history of disease or disability;
  - d. any information received for verifying recipient's income eligibility and amount of medical assistance payments;
  - e. any information received in connection with the identification of legally liable third party resources.
7. To release information about Medicaid recipients only to the IFSSA, its agent, or a Medicaid Waiver recipients case manager or targeted case manager and only when in connection with:
  - a. Providing services for recipients; and
  - b. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of Medicaid covered services.
8. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility of the provider to the agency to assure that all activities under the contract are carried out.

9. To submit claims for services rendered by the provider or employees of the provider and not to submit claims for services rendered by contractors unless the provider is a healthcare facility (e.g. hospital, ICF-MR, nursing home) or a government agency with a contract that meets the requirements described in paragraph 8 of this Agreement. Healthcare facilities and government agencies' may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide Medicaid-covered services rendered pursuant to this Agreement .
10. To comply, if a hospital, nursing facility, provider of home health care and personal care services, hospice, or HMO; with advance directive requirements as required by 42 'Code of Federal Regulations, parts 489, subpart I, and 417.436.
11. To abide by the Indiana Health Coverage Programs Provider Manual, as amended from time to time, the Medicaid Waiver Programs Provider Manual, as amended from time to time, as well as all provider bulletins and notices. Any amendments to the Indiana Health Coverage Programs Provider Manual, the Medicaid Waiver Program, as well as provider bulletins and notices communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" on file with IFSSA or its fiscal agent.
12. To submit timely billing on Medicaid approved claim forms, as outlined in the Medicaid Waiver Programs Provider Manual, in an amount no greater than Provider's usual and customary charge to the general public for the same service.
13. To be individually responsible- and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable Federal and/or State law.
14. To submit claim(s) for Medicaid Waiver reimbursement only after first exhausting all other sources of reimbursement as required by the Indiana Health Coverage Programs Provider Manual, bulletins, and banner pages.
15. To submit claim(s) for Medicaid Waiver reimbursement utilizing the appropriate claims forms and, codes as specified in the Medicaid Waiver Programs Provider Manual, bulletins, and notices.
16. To submit claims that can be documented by Provider as being strictly for:
  - a. those services and/or supplies authorized by the recipients waiver case manager or targeted case manager for individuals with developmental disabilities;
  - b. those services and/or supplies actually provided to the recipient in whose name the claim is being made; and
  - c. compensation that Provider is legally entitled to receive.
17. To accept payment as payment in full the amounts determined by IFSSA or its fiscal agent in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid waiver covered services provided to Medicaid Waiver recipients. Provider agrees not to bill recipients or any member of a recipient's family, for any additional charge for Medicaid Waiver covered services, excluding and co-payment permitted by law.

18. To refund within fifteen (15) days of receipt, to IFSSA or its fiscal agent any duplicate or erroneous payment received.
19. To make repayments to IFSSA or its fiscal agent or arrange to have future payments from the Medicaid or Medicaid Waiver programs withheld, within sixty (60) days of receipt of notice from IFSSA . or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending.
20. To pay interest on overpayment in accordance with IC 12-15-13-3, IC 12-15-21-3, and IC 12-15-23-2.
21. To make full reimbursement to IFSSA or its fiscal agent of any federal disallowance incurred by IFSSA when such disallowance relates to payments previously made to Provider under the Medicaid or Medicaid Waiver programs.
22. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.
23. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Medicaid or Medicaid waiver payments made to Provider, to assure the proper administration of the Medicaid and Medicaid Waiver programs and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in' the "Provider Requirements" Section of the Waiver. Provider Manual and shall include, without being limited to, the following:  
(405/AC 1-5)
  - a. Medical records as specified by Section 1902(a) (27) of Title XIX of the. Social Security Act and any amendments thereto;
  - b. records of all treatments, drugs, services and/or supplies for which vendor payments have been made, or are to be made under the Title XIX Program, including the authority for and the date of administration of such treatment, drug, services and/or supplies;
  - c. any records determined by IFSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program;
  - d. documentation in each recipient's record that will" enable the IFSSA or its agent to verify that each charge is due and proper;
  - e. financial records maintained in the standard, specified form;
  - f. all other records as may be found necessary by the IFSSA or its agent in determining compliance with any Federal or State law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the IFSSA.
24. To cease any conduct that IFSSA or its representative deems to be abusive of the Medicaid or Medicaid Waiver programs.
25. To promptly correct deficiencies in Provider's operations upon request of IFSSA or its fiscal agent.
26. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:
  - a. the petitioner is a person to whom the order is specifically directed;
  - b. the petitioner is aggrieved or adversely affected by the order; and
  - c. the petitioner is entitled to review under the law.

27. Provider must file a statement of issues within the time limits listed below, setting out in detail:
  - a. the specific findings, actions, or determinations of IFSSA from which Provider is appealing;
  - b. with respect to each finding, action or determination, all statutes or rules supporting Provider's contentions of error.
28. Time limits for filing an appeal and the statement of issues are as follows:
  - a. The provider must file an appeal of determination that an overpayment has occurred within sixty (60) days of receipt of IFSSA's determination. The statement of issues must be filed within 60 days of receipt of IFSSA's determination.
  - b. All appeals of actions not described in (a) must be filed within fifteen (15) days of receipt of IFSSA's determination. The statement of issues must be filed within. Forty-five (45) days of receipt of IFSSA's determination.
29. To cooperate with IFSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.
30. To comply with civil rights requirements as mandated by federal and state statutes and regulations by ensuring that no person shall on the basis of race, color, national origin, ancestry, disability, age, sex, or religion be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination in the provision of a Medicaid or Medicaid Waiver-covered service.
31. To comply with 42 Code of Federal Regulations, part 455, .subpart B pertaining to the disclosure of information concerning the ownership and control of the provider, certain business transactions, and information concerning persons convicted of crimes. Said compliance will include, but is not limited to, giving written notice to IFSSA, the State's Medicaid Waiver Specialist and its fiscal agent, at least sixty (60) days before making a change in any of the following: Name (legal name, DBA name, or name as registered with the Secretary of State), address (service location," pay to," "mail to," or home office), federal tax identification number(s), or change in the provider's direct or indirect 'ownership' interest or controlling interest. Pursuant to 42 Code of Federal Regulations, part 455.104(c), IFSSA must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.
32. To furnish to IFSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in Schedule A to this Agreement, which is incorporated here by reference, and to update this information as it may be necessary.
33. That subject to item 32, this Agreement shall be effective as of the date set out in the provider notification letter.
34. If the Provider provides direct services, to provide waiver' services solely as authorized in the recipients Plan of Care/Cost Comparison Budget prepared by the recipients case manager or targeted case manager and as the services are defined in the Medicaid Waiver Provider Manual and the appropriate waiver.



35. To provide at least 30 (thirty) days written notice to the recipient and/or recipient's legal representative, the recipient's case manager or targeted case manager, if applicable, and the State's Medicaid Waiver Specialist before terminating waiver services to a recipient
- a. If the Provider is providing direct services, prior to terminating services, the Provider shall participate in an Interdisciplinary Team meeting to coordinate the transfer of services to a new provider. The Provider agrees to continue serving the recipient until a new provider providing 'similar services is in place, unless written permission has been received from the State's Medicaid Waiver Specialist authorizing the provider to cease providing services before a new provider begin providing.
  - b. If the Provider is providing case management services, the Provider shall participate in an Interdisciplinary team meeting, at which the recipient's new case manager is present. The purpose of the Interdisciplinary meeting will be to coordinate the transfer of case management services to the new case manager. The Provider agrees to continue serving the recipient until a new case manager is serving the recipient, unless written permission has been received from the State's Medicaid Waiver Specialist authorizing the Provider to cease providing services before a new provider begins providing services.
36. To report any incidents (including suspected abuse, neglect or exploitation) to Adult Protective Services or Child Protective Services, the appropriate Area Agency on Aging and the recipient's case manager. If the waiver recipient is developmentally disabled a report shall also be made to the Bureau of Developmental Disabilities Services
37. To comply with Provider and Case Management Standards issued by the Division of Disability, Aging, and Rehabilitative Services, as applicable, and as amended from time to time. These standards are binding upon receipt unless otherwise stated. Receipt will be presumed when the standards or any amendments are mailed to the Provider's current address on file with IFSSA or its fiscal agent.
38. That this Agreement may be terminated as-follows:
- A. By IFSSA or its fiscal agent for Provider's breach of any provision of this Agreement;
  - B. By IFSSA or its fiscal agent, or by Provider, upon 60 days written notice.
39. That this Agreement, upon execution, .supersedes and replaces any provider agreement previously executed by the Provider.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS AND TERMS SET FORTH HEREIN.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 USC 1320a-7b MAYBE PUNISHABLE BY A FINE OF UP TO \$25,000 OR IMPRISONMENT OF NOT MORE THAN FIVE YEARS OR BOTH.

Provider-Authorized Signature - All Schedules

The Owner or an authorized officer of the business entity must complete this section

I certify, under penalty of law, that the information stated in Schedule A is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicated that the information has been falsified; I may be considered for suspension from the program and/or prosecution for Medicaid Fraud. I hereby authorize the Indiana Family and Social Services Administration to make any necessary verifications of the information provided herein, and further authorize and request each educational institution, medical/license board or organization to provide all information that may be required in connection with my application for participation in the Indiana Medicaid Waiver Program.

Provider DBA Name \_\_\_\_\_

Tax ID \_\_\_\_\_

Officer Name \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Telephones Number \_\_\_\_\_

Note: Failure to complete this section will result in the State returning the application for incomplete information.

Revised 1/2002

# Request for Taxpayer Identification Number and Certification

Give form to the  
requester. Do not  
send to the IRS.

**Print or type**  
**See Specific Instructions on page 2.**

Name (as shown on your income tax return)	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	<input type="checkbox"/> Exempt from backup withholding
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number								
			+			+		
or								
Employer identification number								
			+					

## Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. person (including a U.S. resident alien).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
------------------	-------------------------------	--------

## Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**U.S. person.** Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or

- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

- The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as nonresident alien.
- The treaty article addressing the income.
- The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

**Other entities.** Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

**Note.** You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

### Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

**Exempt payees.** Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
2. The United States or any of its agencies or instrumentalities,
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
9. A futures commission merchant registered with the Commodity Futures Trading Commission,
10. A real estate investment trust,
11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
12. A common trust fund operated by a bank under section 584(a),
13. A financial institution,
14. A middleman known in the investment community as a nominee or custodian, or
15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt recipients 1 through 7 <sup>2</sup>

<sup>1</sup>See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup>However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

## Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at [www.socialsecurity.gov/online/ss-5.pdf](http://www.socialsecurity.gov/online/ss-5.pdf). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/businesses/](http://www.irs.gov/businesses/) and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting [www.irs.gov](http://www.irs.gov) or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, **only** the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

**Signature requirements.** Complete the certification as indicated in 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

## What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>1</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship or single-owner LLC	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Sole proprietorship or single-owner LLC	The owner <sup>3</sup>
7. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

<sup>4</sup> List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

## Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

## COUNTY SURVEY

Provider Name: \_\_\_\_\_  
Doing Business as (DBA): \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

Please circle the number of each county in which you are willing to provide the service(s). The Medicaid Waiver Unit database lists waiver providers by the counties they serve; waiver case managers utilize the database to refer waiver clients to providers serving a client's county of residence.

<u>COUNTY</u>	<u>COUNTY</u>	<u>COUNTY</u>
1. ADAMS	32. HENDRICKS	63. PIKE
2. ALLEN	33. HENRY	64. PORTER
3. BARTHOLOMEW	34. HOWARD	65. POSEY
4. BENTON	35. HUNTINGTON	66. PULASKI
5. BLACKFORD	36. JACKSON	67. PUTNAM
6. BOONE	37. JASPER	68. RANDOLPH
7. BROWN	38. JAY	69. RIPLEY
8. CARROLL	39. JEFFERSON	70. RUSH
9. CASS	40. JENNINGS	71. SAINT JOSEPH
10. CLARK	41. JOHNSON	72. SCOTT
11. CLAY	42. KNOX	73. SHELBY
12. CLINTON	43. KOSCIUSKO	74. SPENCER
13. CRAWFORD	44. LAGRANGE	75. STARKE
14. DAVIESS	45. LAKE	76. STEUBEN
15. DEARBORN	46. LAPORTE	77. SULLIVAN
16. DECATUR	47. LAWRENCE	78. SWITZERLAND
17. DEKALB	48. MADISON	79. TIPPECANOE
18. DELAWARE	49. MARION	80. TIPTON
19. DUBOIS	50. MARSHALL	81. UNION
20. ELKHART	51. MARTIN	82. VANDERBURGH
21. FAYETTE	52. MIAMI	83. VERMILLION
22. FLOYD	53. MONROE	84. VIGO
23. FOUNTAIN	54. MONTGOMERY	85. WABASH
24. FRANKLIN	55. MORGAN	86. WARREN
25. FULTON	56. NEWTON	87. WARRICK
26. GIBSON	57. NOBLE	88. WASHINGTON
27. GRANT	58. OHIO	89. WAYNE
28. GREENE	59. ORANGE	90. WELLS
29. HAMILTON	60. OWEN	91. WHITE
30. HANCOCK	61. PARKE	92. WHITLEY
31. HARRISON	62. PERRY	

The list and map on the following pages show each Area Agency on Aging, with the counties included in each AAA's jurisdiction. The Medicaid Waiver Unit suggests that new providers contact each Area Agency in whose counties the provider will deliver waiver services, so the AAA becomes acquainted with new providers in the area. 2/05

# 16 Area Agencies on Aging

## AREA 1

### Northwest Indiana Community Action Corp.

5240 Fountain Dr.  
Crown Point, IN 46307  
(219) 794-1829 or (800) 826-7871  
TTY: (888) 814-7597  
FAX (219) 794-1860  
Web Site: [www.nwi-ca.com](http://www.nwi-ca.com)  
E-Mail: [golund@nwi-ca.org](mailto:golund@nwi-ca.org)  
Gary Olund, Executive Director  
Jennifer Malone, Director of Elderly Services

## AREA 2

### REAL Services, Inc.

1151 S. Michigan St., P.O. Box 1835  
South Bend, IN 46634-1835  
(574) 233-8205 or (800) 552-2916  
FAX (574) 284-2642  
Web Site: [www.realservicesinc.com](http://www.realservicesinc.com)  
Becky Zaseck, President, C.E.O

## AREA 3

### Aging and In-Home Services of Northeast Indiana, Inc.

2927 Lake Avenue  
Fort Wayne, IN 46805-5414  
(260) 745-1200 or (800) 552-3662  
FAX (260) 456-1066  
Web Site: [www.agingihs.org](http://www.agingihs.org)  
E-Mail: [dmccormick@agingihs.org](mailto:dmccormick@agingihs.org)  
Diann McCormick, President

## AREA 4

### Area IV Agency on Aging & Community Action Programs, Inc.

660 North 36th St., P.O. Box 4727  
Lafayette, IN 47903-4727  
(765) 447-7683 or (800) 382-7556  
TDD (765) 447-3307; FAX (765) 447-6862  
E-Mail: [info@areaivagency.org](mailto:info@areaivagency.org)  
Web Site: [www.areaivagency.org](http://www.areaivagency.org)  
Sharon Wood, Executive Director

## AREA 5

### Area Five Agency on Aging & Community Services, Inc.

1801 Smith Street, Suite 300  
Logansport, IN 46947-1577  
(574) 722-4451 or (800) 654-9421  
FAX (574) 722-3447  
E-Mail: [areafive@areafive.com](mailto:areafive@areafive.com)  
Web Site: [www.areafive.com](http://www.areafive.com)  
Michael Meagher, Executive Director

## AREA 6

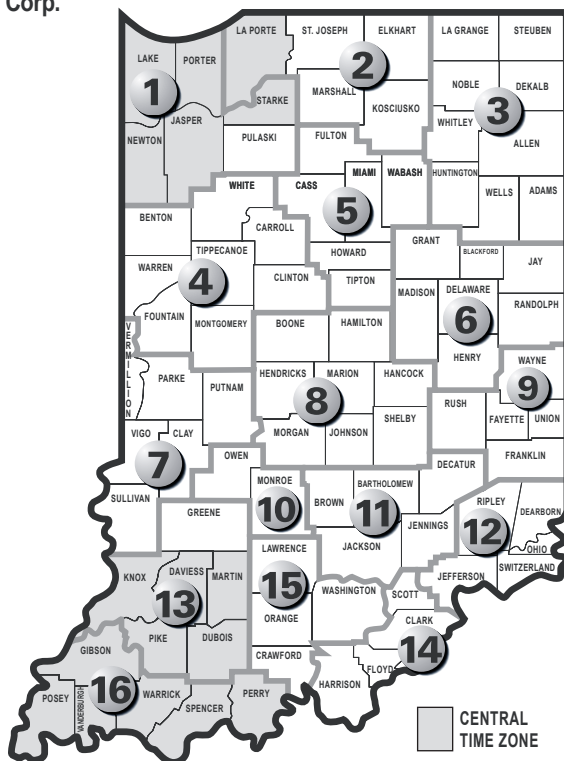
### LifeStream Services, Inc.

1701 Pilgrim Blvd., P.O. Box 308  
Yorktown, IN 47396-0308  
(765) 759-1121 or (800) 589-1121  
TDD (800) 589-1121; FAX (765) 759-0060  
E-Mail: [mail@lifestreaminc.org](mailto:mail@lifestreaminc.org)  
Web Site: [www.lifestreaminc.org](http://www.lifestreaminc.org)  
Kenneth D. Adkins, President/CEO

## AREA 7

### Area 7 Agency on Aging and Disabled West Central Indiana Economic Development District, Inc.

1718 Wabash Ave., P.O. Box 359  
Terre Haute, IN 47808-0359  
(812) 238-1561 or (800) 489-1561  
TDD (800) 489-1561; FAX (812) 238-1564  
E-Mail: [Area7AAD@netscape.net](mailto:Area7AAD@netscape.net)  
Mervin Nolot, Executive Director



## AREA 8

### CICOA Aging and In-Home Solutions

4755 Kingsway Dr., Suite 200  
Indianapolis, IN 46205-1560  
(317) 254-5465 or (800) 489-9550  
FAX (317) 254-5494; TDD (317) 254-5497  
Web Site: [www.cicoa.org](http://www.cicoa.org)  
Duane Etienne, President, C.E.O.

## AREA 9

### Area 9 In-Home & Community Services Agency

520 South 9th St.  
Richmond, IN 47374-6230  
(765) 966-1795, (765) 973-8334 or  
(800) 458-9345  
FAX (765) 962-1190  
E-Mail: [ashepher@indiana.edu](mailto:ashepher@indiana.edu)  
Web Site: [www.iue.indiana.edu/departments/Area 9](http://www.iue.indiana.edu/departments/Area%209)  
Tony Shepherd, Executive Director

## AREA 10

### Area 10 Agency on Aging

630 W. Edgewood Drive  
Ellettsville, IN 47429  
(812) 876-3383 or (800) 844-1010  
FAX (812) 876-9922  
E-Mail: [area10@area10.bloomington.in.us](mailto:area10@area10.bloomington.in.us)  
Web Site: [www.area10.bloomington.in.us](http://www.area10.bloomington.in.us)  
Jewel Echelbarger, Executive Director

## AREA 11

### Aging & Community Services of South Central Indiana, Inc.

1531 13th Street, Suite G-900  
Columbus, IN 47201-1302  
(812) 372-6918 or (866) 644-6407  
FAX (812) 372-7846  
Web Site: [www.agingandcommunityservices.org](http://www.agingandcommunityservices.org)  
E-Mail: [dcantrell@areaxi.org](mailto:dcantrell@areaxi.org)  
Diane Cantrell, Executive Director

## AREA 12

### LifeTime Resources, Inc.

13091 Benedict Drive  
Dillsboro, IN 47018  
(812) 432-5215 or (800) 742-5001  
FAX (812) 432-3822  
Web Site: [www.lifetime-resources.org](http://www.lifetime-resources.org)  
E-Mail: [contactltr@lifetime-resources.org](mailto:contactltr@lifetime-resources.org)  
Sally Beckley, Executive Director

## AREA 13

### Generations

### Vincennes University Statewide Services

1019 North 4th Street  
P.O. Box 314  
Vincennes, IN 47591  
(812) 888-5880 or (800) 742-9002  
FAX (812) 888-4566  
E-Mail: [generations@vinu.edu](mailto:generations@vinu.edu)  
Web Site: [www.generationsnetwork.org](http://www.generationsnetwork.org)  
Anne N. Jacoby, Assistant Vice President

## AREA 14

### LifeSpan Resources, Inc.

426 Bank Street, Suite 100, P.O. Box 995  
New Albany, IN 47151-0995  
(812) 948-8330 or (888) 948-8330  
FAX: (812) 948-0147  
E-Mail: [kstormes@lsr14.org](mailto:kstormes@lsr14.org)  
Web Site: [www.lifespanresources.org](http://www.lifespanresources.org)  
Keith Stormes, Executive Director

## AREA 15

### Hoosier Uplands/Area 15 Agency on Aging and Disability Services

521 West Main Street  
Mitchell, IN 47446  
(812) 849-4457 or (800) 333-2451  
TDD (800) 743-3333; FAX (812) 849-4467  
E-Mail: [area15@hoosieruplands.org](mailto:area15@hoosieruplands.org)  
Web Site: [www.hoosieruplands.org](http://www.hoosieruplands.org)  
David L. Miller, CEO  
Barbara Tarr, Director of Aging and Disability Services

## AREA 16

### Southwestern Indiana Regional Council on Aging, Inc.

16 W. Virginia St., P.O. Box 3938  
Evansville, IN 47737-3938  
(812) 464-7800 or (800) 253-2188  
FAX (812) 464-7843 or (812) 464-7811  
E-Mail: [swirca@swirca.org](mailto:swirca@swirca.org)  
Web Site: [www.swirca.org](http://www.swirca.org)  
Robert J. "Steve" Patrow, Executive Director

To contact your local Area Agency toll-free, call  
**1-800-986-3505**